Bates' Guide to Physical Examination and History Taking

Fourteenth Edition

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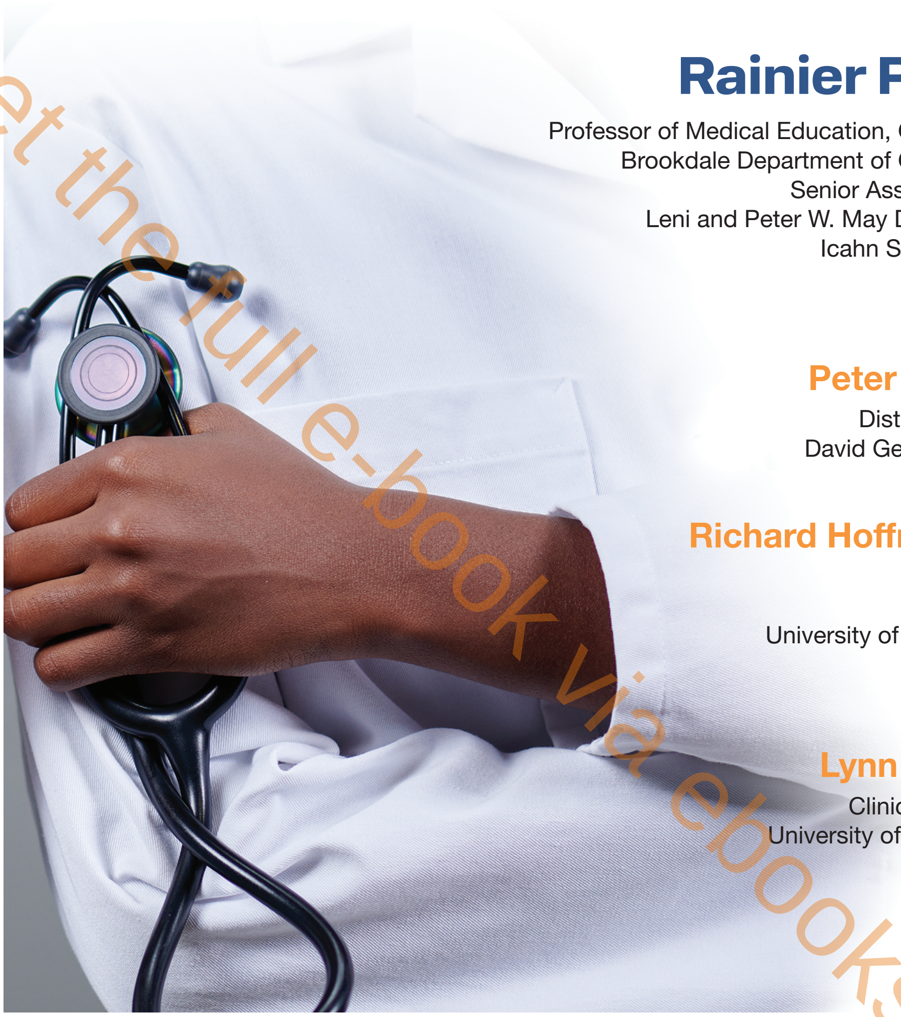

Lead Author and Editor
Rainier P. Soriano, MD
Professor of Medical Education, Geriatrics and Palliative Medicine
Brookdale Department of Geriatrics and Palliative Medicine
Senior Associate Dean for Curricular Affairs
Leni and Peter W. May Department of Medical Education
Icahn School of Medicine at Mount Sinai
New York, New York

Co-Editors
Peter G. Szilagyi, MD, MPH
Distinguished Professor of Pediatrics
David Geffen School of Medicine at UCLA
Los Angeles, California

Richard Hoffman, MD, MPH, FACP
Emeritus Professor
Department of Medicine
University of Iowa Carver College of Medicine
Iowa City, Iowa

Editor Emeritus
Lynn S. Bickley, MD, FACP
Clinical Professor of Internal Medicine
University of New Mexico School of Medicine
Albuquerque, New Mexico

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Acquisitions Editor: Matt Hauber
Development Editor: Deborah Bordeaux
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Manufacturing Coordinator: Margie Orzech
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To Lynn Bickley, whose dedication to the art and science of physical diagnosis has inspired generations of clinicians and laid the foundation for countless students; it is an honor to continue your legacy.

Faculty Contributors

George A. Alba, MD
Assistant Professor of Medicine
Division of Pulmonary and Critical Care Medicine
Massachusetts General Hospital
Harvard Medical School
Boston, Massachusetts

Cara A. Brown, MD, AEMUS-FPD, FACEP
Assistant Professor
Director, Advanced Emergency Ultrasound Fellowship
Department of Emergency Medicine
Icahn School of Medicine at Mount Sinai
New York, New York

Christopher T. Doughty, MD
Assistant Professor of Neurology
Harvard Medical School
Brigham and Women's Hospital
Boston, Massachusetts

Nicola A. Feldman, MD, MS
Resident Physician
Boston Combined Residency Program in Pediatrics
Boston Children's Hospital and Boston Medical Center
Boston, Massachusetts

Rocco M. Ferrandino, MD, MSCR
Assistant Professor
Department of Otolaryngology-Head and Neck Surgery
University of Washington
Seattle, Washington

Raisa Gao, MD, FACOG
Vice Chair
Department of Obstetrics and Gynecology
Huntington Hospital
Northwell Health
Assistant Professor
Donald and Barbara Zucker School of Medicine at Hofstra
Hempstead, New York

Sarah M. Gustafson, MD
Associate Clinical Professor
Division of Pediatric Hospital Medicine
David Geffen School of Medicine at UCLA
Los Angeles, California

Michael L. Herscher, MD
Associate Professor of Medicine and Medical Education
Division of Hospital Medicine
Mount Sinai Hospital
Icahn School of Medicine at Mount Sinai
New York, New York

Alexander R. Lloyd, MD
PM&R Sports Medicine Physician
Assistant Program Director, Sports Medicine Fellowship
Rehabilitation and Performance Medicine
Providence Swedish
Seattle, Washington

Christopher C. Lo, MD
Orbital and Oculofacial Plastic Surgery
Medical Director
Eyesthetica
Los Angeles, California

Stephen A. McCullough, MD
Assistant Professor of Clinical Medicine
Division of Cardiology
Weill Cornell Medicine
New York Presbyterian Hospital
New York, New York

Bret P. Nelson, MD, AEMUS-FPD, FACEP
Professor, Department of Emergency Medicine
System Vice Chair, Education
Chief, Emergency Ultrasound Division
Department of Emergency Medicine
Icahn School of Medicine at Mount Sinai
New York, New York

Matthew E. Pollard, MD
Reproductive Urology
Regional Medical Director, Vice President of Quality and Clinical Excellence
Posterity Health, PC
Nashville, Tennessee

Bess M. Storch, MD
Assistant Professor
Department of Emergency Medicine
Mount Sinai West-Morningside Hospitals
Department of Medical Education
Icahn School of Medicine at Mount Sinai
New York, New York

Preface

I am excited to introduce the fourteenth edition of *Bates' Guide to Physical Examination and History Taking*, a trusted resource that has guided generations of health care learners in developing the essential skills of patient assessment. This edition continues to evolve alongside the practice of medicine, integrating modern diagnostic techniques while preserving the core principles of clinical reasoning and physical diagnosis that remain at the heart of patient care.

The comprehensive updates introduced in the thirteenth edition continue here, reflecting advancements in clinical education, patient care, and medical technology. With input from active clinicians and experienced educators, this edition responds to the changing needs of students and instructors across health care disciplines, ensuring it remains relevant, accessible, and clinically practical. A key focus of this edition is enhancing the usability and clinical application of the physical examination chapters, with refinements that help learners bridge the gap between textbook knowledge and real-world patient care.

This edition expands the **structured health history questions** to provide clearer guidance on how to ask effective, clinically relevant questions and interpret patient responses in ways that inform diagnosis and management. These revisions emphasize the connection between patient narratives, clinical reasoning, and differential diagnosis, helping learners move beyond memorization toward a deeper understanding of history-taking as a critical diagnostic tool. **Discussions of common symptoms** have also been refined, providing a stronger foundation for assessing patient complaints by integrating key historical features, physical exam findings, and considerations for differential diagnosis. Rather than presenting symptoms in isolation, this approach reinforces how clinicians analyze and synthesize information in practice. In addition, recognizing that many patients present with medical devices or prior surgical interventions that require **modifications to standard examination techniques**, this edition includes specific guidance on how to adapt the physical exam in these cases. These updates ensure that learners develop a flexible, patient-centered approach that accounts for real-world complexities in clinical assessment.

New content includes a dedicated chapter on **Point-of-Care Ultrasound (POCUS)** and updates to **Clinical Documentation and Presentation**, equipping learners with the tools to integrate technology-assisted diagnostics and effective communication into clinical workflows. The **Older Adults chapter**, now structured around the **Geriatric 5Ms framework**, provides a comprehensive approach to assessing aging patients, reinforcing the importance of age-specific considerations in physical diagnosis.

Beyond structural and content updates, terminology throughout the text has been refined to ensure clarity, accuracy, and consistency with modern medical language. Where historical medical terms and eponyms are still in use, they have been carefully retained for continuity while ensuring that descriptions are as precise and clinically useful as possible. The **Health Promotion and Counseling** sections have also been expanded, emphasizing patient-centered communication, disease prevention strategies, and clinical reasoning in primary care and specialty settings.

With these updates, the fourteenth edition of *Bates' Guide to Physical Examination and History Taking* remains a cornerstone resource in health care education, equipping students, educators, and practicing clinicians with the knowledge and skills necessary for effective, evidence-based, and compassionate patient care. This edition upholds the highest standards in medical training, ensuring that future health care professionals are well prepared to integrate clinical knowledge, physical exam skills, and patient communication into their practice.

R.P. Soriano, MD
Lead Author and Editor

New Content and Features

The fourteenth edition introduces several new features and expanded content designed to enhance clinical learning and patient assessment skills. These updates improve both usability and content depth, ensuring that learners gain a strong foundation in physical examination, clinical reasoning, and diagnostic techniques.

Layout and Design Enhancements:

- The streamlined double-column layout for Unit 1 has been introduced to improve readability, allowing for a cleaner and more focused presentation of foundational content. Units 2 and 3 retain the familiar two-column layout, providing continuity and maintaining the traditional structure that many readers appreciate.

- We have revamped the overall layout to make navigation easier, ensuring that you can find the information you need quickly and efficiently. This improved design enhances your study experience by reducing the time spent searching for key topics.

- With new, high-quality images added throughout the book provide greater visual clarity, reinforcing important physical examination techniques and clinical findings. These images are designed to support and enhance the textual content, making complex concepts more intuitive.

- Additional tables have been incorporated to organize information more clearly. These tables help distill complex data into easily digestible formats, aiding in quicker comprehension and retention of critical facts.

Refinements in Language and Clinical Terminology:

- Language and terminology have been refined to ensure clarity, precision, and accessibility, reflecting best practices in clinical communication while maintaining consistency with modern health care education standards.

Enhancements to Regional Physical Examination Chapters:

- The inclusion of common symptoms with high-yield health history questions is aimed at enhancing clinical reasoning-focused interviews. These structured questions guide learners in asking the right questions during patient assessments, ultimately improving diagnostic accuracy.

- New sections on high-yield Point-of-Care Ultrasound (POCUS) techniques in selected regional physical examination chapters provide essential skills for modern diagnostic practices. Learning these techniques alongside time-honored physical exam skills will give learners a competitive edge in clinical settings and develop a more comprehensive diagnostic approach.

- We have added new tables on physical examination modifications for patients with clinical devices. These tables offer practical guidance on adapting exams for patients with special needs, ensuring comprehensive, patient-centered, and sensitive care.

- The new clinical reasoning–focused interpretation of sample documentations in regional chapters will help learners understand how to effectively document findings and think critically about assessments. This skill is crucial for developing accurate patient records and improving overall patient care.

- Updated recommendations in the Health Promotion and Counseling sections ensure you have access to the latest guidelines and best practices for patient care. Staying current with these recommendations is vital for providing the best possible advice and treatment to patients.

Specific Chapter Revisions and Additions:

- The addition of new chapters on POCUS and Documentation and Presentation expands the scope of the textbook, providing learners with essential modern techniques and skills that are increasingly important in clinical practice.

- The Genitourinary (GU) content has been reorganized, and the Musculoskeletal (MSK) chapter has been split, allowing for a more detailed and focused presentation of each area. This reorganization allows for a deeper understanding of each area, enhancing overall clinical knowledge and application.

- The introduction of the 5Ms framework in the Older Adults chapter enhances health history and assessment for older patients, offering a comprehensive approach to evaluating and managing geriatric care. This framework ensures a thorough and holistic approach to geriatric care, which is crucial given the aging population.

These updates and enhancements ensure that the fourteenth edition remains a comprehensive and indispensable resource for clinical skills training and education. With these improvements, learners will be well equipped to succeed in their clinical studies and future careers, confident in their ability to perform thorough physical examinations, apply clinical reasoning, and provide high-quality patient care.

ORGANIZATION

The book comprises three units: *Foundations of Health Assessment, Regional Examinations,* and *Special Populations.*

Unit 1, Foundations of Health Assessment, focuses on essential skills and knowledge required for the clinical encounter. This unit with nine chapters begins with foundational skills crucial to the clinical setting, followed by effective interviewing, communication, and interpersonal skills. The subsequent chapters cover the health history, physical examination, and the processes of clinical reasoning, assessment, and planning. In addition, this unit includes new chapters on clinical documentation and presentation, as well as the basic principles and techniques of point-of-care ultrasound. Health maintenance and screening are also addressed, along with evaluating clinical evidence, ensuring a comprehensive foundation for effective patient assessment and clinical decision making.

Unit 2, Regional Examinations, covers comprehensive regional examinations from head to toe. This unit with 18 chapters begins with an overview of the general survey, vital signs, and pain assessment, followed by cognition, behavior, and mental status. Subsequent chapters detail the examination of the skin, hair, and nails; head and neck; eyes; ears and nose; throat and oral cavity; thorax and lungs; cardiovascular system; and peripheral vascular system. The unit continues with the examination of the breasts and axillae, abdomen, anus and rectum, and the pelvis and genitourinary system, with separate chapters for different anatomical structures. The musculoskeletal system is covered in two chapters, focusing on the neck, shoulders, and upper extremities, and the lumbosacral spine, hip, and lower extremities, respectively. The unit concludes with a detailed examination of the nervous system. Each chapter includes a review of relevant anatomy and physiology, common symptoms encountered in the health history, detailed descriptions and images of examination techniques, a sample written record, comparative tables of abnormalities, and extensive references from recent clinical literature. Important topics for health promotion and counseling are now placed at the end of each chapter to facilitate a more focused understanding of these complex issues.

Unit 3, Special Populations, addresses health assessments across different stages of life, including three chapters on children (infancy through adolescence), pregnant individuals, and older adults.

ADDITIONAL RESOURCES

Bates' Pocket Guide to Physical Examination and History Taking

As a practical companion to *Bates' Guide to Physical Examination and History Taking, 14th Edition*, we highly recommend the *Bates' Pocket Guide to Physical Examination and History Taking, 10th Edition*. Together, these two resources are designed to support learners at every stage—whether laying the groundwork in the classroom or applying knowledge in real-time clinical settings.

The full textbook delivers comprehensive, in-depth instruction on examination techniques, clinical reasoning, and foundational principles of patient care. It is best suited for structured study, offering the detail and context needed to build lasting understanding and clinical confidence.

The Pocket Guide complements this by serving as a concise, accessible reference at the bedside or point of care. Its compact format makes it ideal for quick consultation during clinical encounters, while its clear summaries, updated algorithms, and new illness scripts help reinforce core concepts and support diagnostic reasoning in the moment. The continued inclusion of clinical algorithms reflects their enduring value and the consistently strong feedback from learners and clinicians alike.

Used together, the textbook and Pocket Guide form a dynamic and integrated learning system—helping learners bridge the gap between knowledge and practice with clarity, confidence, and ease.

Bates' Videos

The Bates' video series is an essential adjunct for mastering the many techniques of physical examination. Comprehensive videos bring clinical skills to life through clear, structured demonstrations organized into three integrated collections:

Physical Examination Series: This core series features 18 volumes of head-to-toe and systems-based physical examination videos. Updated and reorganized for clarity and consistency, each video emphasizes relevant anatomy, step-by-step examination techniques, and common pathologic findings. Learners observe experienced clinicians performing regional exams and applying techniques such as inspection, palpation, percussion, and auscultation—across both general and special populations.

Communication and Interpersonal Skills Series: This 27-video series highlights the essential human side of clinical practice. Learners watch clinicians demonstrate foundational communication and interpersonal skills, from building rapport and gathering information to navigating difficult conversations. These skills are critical for effective, compassionate care and will serve as a lifelong foundation for professional growth.

OSCE Clinical Skills Series: Designed to strengthen clinical reasoning and exam readiness, this series includes 15 realistic, scenario-based patient encounters that mirror Objective Structured Clinical Examinations (OSCEs). Each video features a student evaluating a patient with a common presenting problem—such as chest pain, sore throat, or abdominal pain—interspersed with guiding questions and key teaching points. These videos help learners apply their knowledge in context and prepare for both formative assessments and real-world patient care.

Students are encouraged to use the textbook, pocket guide, and video series together as a cohesive learning system—studying the textbook to build foundational knowledge, using the pocket guide to support clinical application, and revisiting the videos to visually reinforce key techniques. Engaging with these resources repeatedly and at different stages of learning helps solidify understanding, sharpen skills, and build confidence in both the classroom and clinical environment.

The Bates' video series is available via Lippincott® Connect as the *Bates' Visual Guide to Physical Examination*. Purchase *Bates' Guide to Physical Examination and History Taking*, Lippincott® Connect version with Videos, for access to the videos, assessment, and other dynamic resources that enhance your learning.

Bates' Visual Guide to Physical Examination is available for purchase by institutions and enables seamless, concurrent access for all students, with options for institutions to subscribe to the full range of videos or select collections. Each video has a unique, stable URL that instructors can provide in their Learning Management Systems for easy student access.

Acknowledgments

Bates' Guide to Physical Examination and History Taking has always been a collaborative effort driven by a singular goal: to honor and support the lifelong learner—student, teacher, and practitioner—in mastering the evolving art and science of clinical medicine. This fourteenth edition continues this tradition, bringing together contributions from a diverse group of dedicated professionals committed to excellence in physical diagnosis and patient care. With this edition, *Dr. Rainier P. Soriano* assumes the role of lead author and editor, building on the solid foundation established by previous editions. He brings a deep commitment to integrating traditional physical examination with evolving best practices in clinical teaching.

Profound appreciation is extended to *Dr. Lynn S. Bickley*, who skillfully led the guide from the seventh through the thirteenth editions. Her vision and clarity helped shape generations of learners. Gratitude is also owed to *Dr. Peter L. Szilagyi*, whose contributions since the eighth edition have greatly enriched the content, and to *Dr. Richard M. Hoffman*, whose expertise since the twelfth edition has significantly advanced the integration of clinical evidence and health promotion strategies throughout the guide.

This edition also benefited greatly from the insights and contributions of a number of expert reviewers and advisors—active clinicians and educators who embody the intersection of bedside skills and clinical teaching. Their feedback ensures that the content remains accurate, relevant, and grounded in real-world practice. The contributions of the following esteemed colleagues are gratefully acknowledged: *George A. Alba, MD; Cara A. Brown, MD; Christopher T. Doughty, MD; Nicola A. Feldman, MD, MS; Rocco M. Ferrandino, MD, MSCR; Raisa Gao, MD; Sarah M. Gustafson, MD; Michael L. Herscher, MD; Alexander R. Lloyd, MD; Christopher C. Lo, MD; Stephen A. McCullough, MD; Bret P. Nelson, MD; Matthew E. Pollard, MD;* and *Bess M. Storch, MD.*

The production of the *Bates' Guide to Physical Examination and History Taking*, fourteenth edition is a complex endeavor requiring extraordinary coordination and meticulous attention to detail. Special thanks go to Freelance Development Editor *Kelly Horvath*, whose editorial precision and dedication brought coherence and excellence to every chapter. Additional heartfelt acknowledgments go to Development Editor *Deborah Bordeaux*, who has guided the development of the content; Senior Editorial Coordinator *Sean Hanrahan*, who has managed the editorial process; Marketing Manager *Kirsten Watrud*, and Production Project Manager *Catherine Ott* at Wolters Kluwer, whose oversight ensured the successful execution of every phase. Gratitude is also extended to Manager of Graphic Arts & Design *Stephen Druding*, Art Director of Illustration *Jennifer Clements* at Wolters Kluwer, and the team at *Body Scientific International*, for their creation of updated, high-quality illustrations; to photographer *Mike Stog* at DesignWorksVisualMedia and to *Liz*

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The talent, insight, and dedication of all those involved in this edition uphold the long-standing tradition of excellence that has made the *Bates' Guide to Physical Examination and History Taking*, reaffirming its role as the premier resource in the teaching and learning of clinical skills.

Contents

Faculty Contributors *vi*
Preface *viii*
New Content and Features *x*
Acknowledgments *xiv*
List of Tables *xxix*

UNIT 1

Foundations of Health Assessment 1

CHAPTER 1

Foundational Skills Essential to the Clinical Encounter 1

THE CLINICAL ENCOUNTER 1

APPROACH TO THE CLINICAL ENCOUNTER 2

STRUCTURE AND SEQUENCE OF THE CLINICAL ENCOUNTER 2
Stage 1: Initiating the Encounter 3
Stage 2: Gathering Information 8
Stage 3: Performing the Physical Examination 9
Stage 4: Explaining and Planning 9
Stage 5: Closing the Encounter 10

DISPARITIES IN HEALTH CARE 10
Social Determinants of Health 11
Racism and Bias 11
Cultural Humility 13

OTHER MAJOR CONSIDERATIONS 14
Spirituality 14
Medical Ethics 14
Decisional Capacity 16
Approach to a Clinical Ethical Dilemma 16

REFERENCES 17

CHAPTER 2

Interviewing, Communication, and Interpersonal Skills 21

ORGANIZING PATIENT–CLINICIAN COMMUNICATION STRATEGIES 22

ESTABLISHING THE FOUNDATION OF COMMUNICATION 22
Active (Attentive) Listening 22

BUILDING THE INTERACTION 22
Guided Questioning 22

STRENGTHENING THE RELATIONSHIP 24
Empathic Responses 24
Summarization 24
Transitions 25
Validation 25
Partnering 25
Empowering the Patient 25
Reassurance 25

ADDRESSING SENSITIVE TOPICS 26

PRACTICING LEGAL AND ETHICAL COMMUNICATION 26
Informed Consent 26
Collaborating with a Medical Interpreter 27

USING ADVANCED COMMUNICATION STRATEGIES 27
Appropriate Verbal Communication 27
Appropriate Nonverbal Communication 29

NAVIGATING COMPLEX DISCUSSIONS 31
Disclosing Serious News 31
Advance Care Planning 32

ENCOURAGING PATIENT SELF-EFFICACY 34
Motivational Interviewing (MI) 34

ENHANCING INTERPROFESSIONAL COMMUNICATION 34

MANAGING CHALLENGING PATIENT SITUATIONS AND BEHAVIORS 35

BEING PATIENT-CENTERED IN COMPUTERIZED CLINICAL SETTINGS 40

LEARNING COMMUNICATION SKILLS FROM STANDARDIZED PATIENTS 41

REFERENCES 42

CHAPTER 3

Health History 45

HEALTH HISTORY 45
Different Kinds of Health Histories 46
Determining the Scope of Your Patient Assessment: Comprehensive or Focused? 46
Subjective versus Objective Data 47

COMPONENTS OF THE ADULT HEALTH HISTORY 47
Initial Patient Information 48
Gather Information about the Patient's Chief Concern or Presenting Concern 48
Gather Information about the Patient's History of Present Illness 48
Gather Information about the Patient's Past Medical History 50
Gather Information about the Patient's Family History 52
Gather Information about the Patient's Personal and Social History 52
Review of Systems 60

RECORDING YOUR FINDINGS 61

MODIFICATION OF THE CLINICAL INTERVIEW FOR VARIOUS CLINICAL SETTINGS 61

REFERENCES 63

CHAPTER 4

Physical Examination 65

ROLE OF THE PHYSICAL EXAMINATION IN THE ERA OF TECHNOLOGY 65

CONDUCTING CARDINAL TECHNIQUES OF EXAMINATION 66
Auscultating Through Clothing in Clinical Practice 66

BEGINNING THE PHYSICAL EXAMINATION 67
Reflecting on Your Approach 67
Optimizing the Examination Environment 67
Preparing Your Equipment 67
Enhancing Patient Comfort 67
Observing Standard and Universal Precautions 72

OPTIMIZING THE SEQUENCE, SCOPE, AND POSITIONING OF EXAMINATION 72
Sequence of Examination 75
Positioning of Examination 75
Scope of Examination 75

PERFORMING A HEAD-TO-TOE PHYSICAL EXAMINATION 75

ADAPTING THE PHYSICAL EXAMINATION: SPECIFIC PATIENT CONDITIONS 81

RECORDING YOUR FINDINGS 82

REFERENCES 83

CHAPTER 5

Clinical Reasoning 85

DEVELOPING A DIFFERENTIAL DIAGNOSIS: MASTERING CLINICAL REASONING 85

CLINICAL REASONING PROCESS 85

BASIC STRUCTURE OF THE CLINICAL REASONING PROCESS 85
Step 1: Gathering Initial Patient Information 86
Step 2: Organizing and Interpreting Clinical Information 86
Step 3: Synthesizing Clinical Information and Developing the Problem Representation 88
Step 4: Generating Hypotheses by Searching for the Probable Cause of the Findings 88
Step 5: Testing Hypotheses and Establishing a Working Diagnosis 91
Step 6: Planning the Diagnostic and Treatment Strategy 91

CLINICAL DIAGNOSTIC ERRORS 92

CLINICAL REASONING: DOCUMENTATION 92

REFERENCES 94

CHAPTER 6

Clinical Documentation and Oral Presentation 95

NAVIGATING COMMUNICATION IN HEALTH CARE 95
Written Documentation in Electronic Health Records 95
Oral Presentations in Health Care 96

DOCUMENTING HISTORY AND PHYSICAL EXAMINATION NOTES 98
Initial Information 98
Source and Reliability 98
Chief Concern 98
History of Present Illness 99
Prior Health History 102
Family History 103
Social History 103
Review of Systems 103
Physical Examination 103
Assessment and Plan 105

CONDUCTING ORAL PRESENTATIONS FOR NEW PATIENTS 109

DOCUMENTING PROGRESS NOTES 109

ADDRESSING SPECIAL CONSIDERATIONS IN CLINICAL DOCUMENTATION 112

REFERENCES 115

CHAPTER 7

Health Maintenance and Screening 116

CONCEPT OF PREVENTIVE CARE 116

GUIDELINE RECOMMENDATIONS 116
United States Preventive Services Task Force Approach 116

SCREENING 118

BEHAVIORAL COUNSELING 119
Stages of Behavioral Change Model 119
Structured Counseling Models: Five As and FRAMES 121

IMMUNIZATION 122

SCREENING GUIDELINES FOR ADULTS 125
Screening for Substance Use Disorders, Including Misuse of Prescription and Illicit Drugs 125
Screening for Intimate Partner Violence in Females of Reproductive Age 126
Screening for Unhealthy Alcohol Use 126
Screening for Tobacco Use 127
Screening for Sexually Transmitted Infections: Syphilis, Chlamydia, and Gonorrhea 128
Screening for Human Immunodeficiency Virus 129
Screening for Prediabetes and Type 2 Diabetes 129

COUNSELING GUIDELINES FOR ADULTS 130
Counseling for Unhealthy Alcohol Use 130
Counseling for Tobacco Smoking Cessation 130
Counseling on Sexually Transmitted Infections 131

IMMUNIZATION GUIDELINES FOR ADULTS 132
Influenza Vaccine 132
Pneumococcal Vaccine 132
Respiratory Syncytial Virus Vaccine 133
COVID-19 Vaccine 133
Mpox Vaccine 133
Varicella Vaccine 134
Herpes Zoster Vaccine 134
Tetanus, Diphtheria, Pertussis Vaccine 134
Human Papillomavirus Vaccine 134
Hepatitis A Vaccine 135
Hepatitis B Vaccine 135

PREVENTIVE MEDICATION GUIDELINES 135
Prevention of Human Immunodeficiency Virus Infection: Pre-exposure Prophylaxis 135

PREVENTIVE CARE IN SPECIAL POPULATIONS 135

DISEASE-SPECIFIC RECOMMENDATIONS 135

REFERENCES 135

CHAPTER 8

Evaluating Clinical Evidence 139

INTRODUCTION 139

USING ELEMENTS OF THE HISTORY AND PHYSICAL EXAMINATION AS DIAGNOSTIC TESTS 139

EVALUATING DIAGNOSTIC TESTS: VALIDITY 140
Sensitivity and Specificity 141
Predictive Values 141
Prevalence of Disease 141
Likelihood Ratios 142

APPLYING CONCEPTS TO EVALUATING ABDOMINAL PAIN 142

APPLYING CONCEPTS TO SCREENING TESTS 143
Fagan Nomogram 143
Natural Frequencies 143

EVALUATING DIAGNOSTIC TESTS: REPRODUCIBILITY 144
Kappa Score 145
Precision 145

CRITICALLY APPRAISING THE CLINICAL EVIDENCE 146
Are the Results Valid? 146
What Are the Results? 147
How Can You Apply the Results to Patient Care? 148

COMMUNICATING CLINICAL EVIDENCE TO PATIENTS 148

REFERENCES 148

CHAPTER 9

Basic Principles and Techniques: Point-of-Care Ultrasound 150

POINT-OF-CARE ULTRASOUND 150
Goal of the Chapter 150
Enhancing Clinical Assessment: Insonation 154

SOUND WAVES AND ULTRASOUND BASICS 154
Sound Waves 154
Acoustic Impedance in Ultrasound Imaging 154

ULTRASOUND EQUIPMENT AND TECHNIQUE 154
Ultrasound Transducers 154
Image Acquisition 156

UNDERSTANDING IMAGING MODES 159
B-Mode (Brightness Mode) 159
M-Mode (Motion Mode) 159
Doppler Modes, Color, and Pulsed Wave 160

ULTRASOUND IMAGE OPTIMIZATION ("KNOBOLOGY") 161
Machine Settings and Adjustments 161

REFERENCES 162

UNIT 2

Regional Examinations 163

CHAPTER 10

General Survey, Vital Signs, and Pain 163

HEALTH HISTORY: GENERAL APPROACH 163
Fatigue and Weakness 163
Fever and Night Sweats 165
Weight Change 166
Pain 166

PHYSICAL EXAMINATION: GENERAL APPROACH 169

TECHNIQUES OF EXAMINATION 169
Perform a General Survey 169

Measure Height and Weight 171
Assess Vital Signs 173
Measure Blood Pressure 173
Examine Arterial Pulses for Rate and Rhythm 182
Observe Respiratory Rate, Rhythm, Depth, and Effort 183
Measure Core Body Temperature 183
Assess for Acute and Chronic Pain 185
Consider Health Disparities in Pain 188

SPECIAL TECHNIQUES AND MANEUVERS 188
Measure Orthostatic Blood Pressures 188
Special Patient-Related Situations 188
Out-of-Office and Self-Monitoring of Blood Pressure 189

RECORDING YOUR FINDINGS 191

HEALTH PROMOTION AND COUNSELING: EVIDENCE AND RECOMMENDATIONS 192
Achieving Optimal Weight 192

REFERENCES 194

CHAPTER 11
Cognition, Behavior, and Mental Status 197

ANATOMY AND PHYSIOLOGY 197

HEALTH HISTORY: GENERAL APPROACH 200
Anxiety and Excessive Worrying 201
Depressed Mood 202
Memory Problems 204
Medically Unexplained Symptoms 205

PHYSICAL EXAMINATION: GENERAL APPROACH 205

TECHNIQUES OF EXAMINATION 206
Assess Appearance and Behavior Including Level of Consciousness 206
Assess Speech and Language 208
Assess Mood 209
Assess Thought Process and Perceptions 209
Assess Cognitive Function 214
Assess Higher Cognitive Functions 216

RECORDING YOUR FINDINGS 217

HEALTH PROMOTION AND COUNSELING: EVIDENCE AND RECOMMENDATIONS 218
Screening for Depression 218
Screening for Anxiety Disorders 219
Screening for Neurocognitive Disorders 220

REFERENCES 235

CHAPTER 12
Skin, Hair, and Nails 239

ANATOMY AND PHYSIOLOGY 239
Skin 239
Hair 240
Nails 240
Pilosebaceous Glands and Sweat Glands 240

HEALTH HISTORY: GENERAL APPROACH 241
Skin Lesions 241
Rashes and Itching (Pruritus) 242
Hair Loss or Alopecia 243
Nail Changes 244

DESCRIBING SKIN LESIONS 246
Primary Lesions 248
Other Features of Skin Lesions 250

PHYSICAL EXAMINATION: GENERAL APPROACH 252
Skin Examination Setup 252

TECHNIQUES OF EXAMINATION 254
Examine the Hair and Scalp—Seated 254
Examine the Head and Neck—Seated 255
Examine the Upper Back—Seated 255
Examine the Shoulders, Arms, and Hands—Seated 255
Examine the Chest and Abdomen—Seated 256
Examine the Anterior Thighs and Legs—Seated 256
Examine the Feet and Toes—Seated 256
Examine the Lower Back, Posterior Thighs, and Legs—Standing 257
Integrate a Full-Body Skin Examination 257

SPECIAL TECHNIQUES AND MANEUVERS 257
Instructing the Patient in Skin Self-Examination 257
Examining the Patient with Hair Loss 259
Evaluating the Patient Who Is Confined to a Bed 259
Modifications in Physical Examinations: Best Practices for Specialized Patient Populations 261

RECORDING YOUR FINDINGS 262

POINT-OF-CARE ULTRASOUND EXAMINATION 265
Distinguishing Between Cellulitis and Abscess 265

HEALTH PROMOTION AND COUNSELING: EVIDENCE AND RECOMMENDATIONS 267
Skin Cancer Epidemiology 268
Skin Cancer Prevention 268
Clinician Skin Cancer Screening 269
Skin Self-Examination 270

REFERENCES 298

CHAPTER 13
Head and Neck 300

ANATOMY AND PHYSIOLOGY 300
Head and Neck 300
Great Vessels 300
Midline Structures and Thyroid Gland 303
Cervical Lymph Nodes 304

HEALTH HISTORY: GENERAL APPROACH 306
Neck or Thyroid Mass or Lump 306

PHYSICAL EXAMINATION: GENERAL APPROACH 308

TECHNIQUES OF EXAMINATION 308
Examine the Hair 308
Examine the Scalp 308
Examine the Skull 308
Inspect Facial Contours 309
Inspect the Skin on the Head and Face 309
Palpate the Cervical Lymph Nodes 309
Examine the Trachea 310
Inspect the Thyroid Gland 311
Palpate the Thyroid Gland: Posterior Approach 312
Palpate the Thyroid Gland: Anterior Approach 313
Examine the Carotid Arteries and Jugular Veins 313

RECORDING YOUR FINDINGS 313

HEALTH PROMOTION AND COUNSELING: EVIDENCE AND RECOMMENDATIONS 314
Screening for Thyroid Dysfunction 314
Screening for Thyroid Cancer 315

REFERENCES 318

CHAPTER **14**

Eyes 319

ANATOMY AND PHYSIOLOGY 319
Orbital Anatomy 319
Anterior Ocular Structures 319
Lacrimal Apparatus 320
Optical Structures 321
Posterior Ocular Structures 321
Visual Pathway and Fields 322
Autonomic Nerve Supply to the Eyes 324
Extraocular Muscles 324

HEALTH HISTORY: GENERAL APPROACH 325
Blurred Vision 325
Eye Redness or Pain 326

PHYSICAL EXAMINATION: GENERAL APPROACH 328

TECHNIQUES OF EXAMINATION 328
Test Visual Acuity 328
Assess Visual Fields 329
Test Color Vision and Contrast Sensitivity 330
Assess Eye Position and Alignment 331
Inspect the Eyebrows 331
Inspect the Eyelids and Eyelashes 331
Inspect the Lacrimal Apparatus 331
Inspect the Conjunctivae and Sclerae 332
Inspect the Cornea, Iris, and Lens 332
Inspect the Pupils 332
Assess the Pupillary Light Reactions 332
Assess the Pupillary Near Reaction 333
Assess Conjugate Movements 333
Test Extraocular Muscle Movements 334
Test for Convergence 334
Perform a Funduscopic Examination (Direct Ophthalmoscopy) 335

SPECIAL TECHNIQUES AND MANEUVERS 339
Assessing Eye Protrusion (Proptosis or Exophthalmos) 339
Examining for Nasolacrimal Duct Obstruction 340
Managing Foreign Body in the Eye 340
Testing for Functional Impairment of the Optic Nerves 341
Modifications in Physical Examinations: Best Practices for Specialized Patient Populations 341

RECORDING YOUR FINDINGS 343

HEALTH PROMOTION AND COUNSELING: EVIDENCE AND RECOMMENDATIONS 344
Visual Impairment 344
Screening for Glaucoma 344
UV-Related Eye Injuries 345

REFERENCES 359

CHAPTER **15**

Ears and Nose 360

EAR: ANATOMY AND PHYSIOLOGY 360
External Ear 360
Middle Ear 360
Inner Ear 361
Hearing Pathways 362
Vestibular System and Equilibrium 362

NOSE: ANATOMY AND PHYSIOLOGY 362
Nasal Septum 363
Turbinates and Meatuses 363
Paranasal Sinuses 363
Olfaction Pathway 364

HEALTH HISTORY: GENERAL APPROACH 364
Hearing Loss 364
Earache and Ear Discharge 366
Ringing in the Ear (Tinnitus) 367
Dizziness and Lightheadedness 368
Nasal Discharge (Rhinorrhea) and Nasal Congestion 370
Nosebleed (Epistaxis) 371

PHYSICAL EXAMINATION: GENERAL APPROACH 372

EAR: TECHNIQUES OF EXAMINATION 372
Examine the Auricle and Surrounding Tissue and Palpate the Tragus and Mastoid 373
Examine the Ear Canals and Tympanic Membranes (Otoscopy) 373
Test Auditory Acuity (Gross Hearing) 375
Test for Conductive versus Sensorineural Hearing Loss 375

EAR: SPECIAL TECHNIQUES AND MANEUVERS 377
Modifications in Physical Examinations: Best Practices for Specialized Patient Populations 377

NOSE AND PARANASAL SINUS: TECHNIQUES OF EXAMINATION 379
Inspect the Anterior and Inferior Surfaces of the Nose 379
Test for Nasal Obstruction 379
Inspect the Nasal Cavity and Mucosa 379

Inspect the Nasal Septum 380
Inspect the Nasal Turbinates and Meatuses 380
Palpate the Paranasal Sinuses 380

RECORDING YOUR FINDINGS 381

HEALTH PROMOTION AND COUNSELING: EVIDENCE AND RECOMMENDATIONS 382
Screening for Hearing Loss 382

REFERENCES 389

CHAPTER 16

Throat and Oral Cavity 390

ANATOMY AND PHYSIOLOGY 390
Mouth, Gingiva, and Teeth 390
Tongue 391
Gustation Pathway 392
Pharynx 392

HEALTH HISTORY: GENERAL APPROACH 393
Sore Throat 393
Bleeding or Swollen Gums 394
Hoarseness 395
Malodorous Breath (Halitosis) 396

PHYSICAL EXAMINATION: GENERAL APPROACH 398

TECHNIQUES OF EXAMINATION 398
Inspect the Lips and Oral Mucosa 398
Palpate the Oral Mucosa 398
Inspect the Gingiva and Teeth 399
Inspect the Roof and Floor of the Mouth 399
Inspect the Tongue 399
Test the Hypoglossal Nerve 400
Palpate the Tongue 400
Inspect the Soft Palate, Anterior and Posterior Pillars, Uvula, Tonsils, and Pharynx 401
Test the Vagus Nerve 401

SPECIAL TECHNIQUES AND MANEUVERS 401
Modifications in Physical Examinations: Best Practices for Specialized Patient Populations 401

RECORDING YOUR FINDINGS 401

HEALTH PROMOTION AND COUNSELING: EVIDENCE AND RECOMMENDATIONS 403
Oral Health 404
Screening for Oral and Pharyngeal Cancer 404

REFERENCES 416

CHAPTER 17

Thorax and Lungs 417

ANATOMY AND PHYSIOLOGY 417
Surface Anatomy: Vertical Axis 418
Surface Anatomy: Chest Circumference 419
Lungs, Fissures, and Lobes 421
Trachea and Major Bronchi (Tracheobronchial Tree) 423
Pleurae 424
Mechanics and Physiology of Breathing 424
Breath Sounds (Lung Sounds) 425

HEALTH HISTORY: GENERAL APPROACH 425
Shortness of Breath (Dyspnea) and Wheezing 426
Cough 427
Blood-Streaked Sputum (Hemoptysis) 428
Chest Pain/Discomfort 429
Daytime Sleepiness, Snoring, and Disordered Sleep 431

PHYSICAL EXAMINATION: GENERAL APPROACH 432

TECHNIQUES OF EXAMINATION 433
Survey the Thorax and Respiration 433
Inspect the Thorax 433
Palpate the Thorax 435
Assess for Thoracic Expansion (Lung Excursion) 435
Assess for Tactile Fremitus 436
Percuss the Thorax 437
Posterior Chest 438
Anterior Chest 438
Identify Extent of Diaphragmatic Excursion 439
Auscultate the Lungs for Breath Sounds 441
Auscultate for Adventitious (Added) Sounds 441
Assess Transmitted Voice Sounds 444

SPECIAL TECHNIQUES AND MANEUVERS 444
Clinically Assess Pulmonary Function 444
Assess Forced Expiratory Time 444
Identify a Fractured Rib 445
Modifications in Physical Examinations: Best Practices for Specialized Patient Populations 445

RECORDING YOUR FINDINGS 447

POINT-OF-CARE ULTRASOUND EXAMINATION 448
Detecting Congestive Heart Failure, Pneumothorax, and Pleural Effusion 448

HEALTH PROMOTION AND COUNSELING: EVIDENCE AND RECOMMENDATIONS 451
Lung Cancer 451
Latent Tuberculosis 452
Obstructive Sleep Apnea 453

REFERENCES 470

CHAPTER 18

Cardiovascular System 472

ANATOMY AND PHYSIOLOGY 472
Mediastinum, Heart, and Great Vessels 472
Conduction System 473
Heart as a Pump 475
Cardiac Circulation 476
Cardiac Cycle 477
Arterial Pulses and Blood Pressure 477

Jugular Venous Pressure and Pulsations 480
Relation of Cardiac Findings to the Chest Wall 481
Heart Sounds 482
Heart Murmurs 485

HEALTH HISTORY: GENERAL APPROACH 485
Chest Pain 485
Palpitations 486
Shortness of Breath 487
Swelling (Edema) 488
Fainting (Syncope) 489

PHYSICAL EXAMINATION: GENERAL APPROACH 490

TECHNIQUES OF EXAMINATION 491
Measure Blood Pressure and Heart Rate 492
Identify Jugular Venous Pressure 492
Auscultate for Carotid Bruits 496
Palpate the Carotid Arteries 496
Inspect the Precordium 497
Palpate the Precordium 497
Auscultate the Precordium 499
Auscultate for S_1 and S_2 503
Auscultate for Splitting of Heart Sounds 503
Auscultate for Heart Murmurs 503

SPECIAL TECHNIQUES AND MANEUVERS 509
Bedside Maneuvers to Identify Murmurs and Heart Failure 509
Modifications in Physical Examinations: Best Practices for Specialized Patient Populations 510

RECORDING YOUR FINDINGS 513

POINT-OF-CARE ULTRASOUND EXAMINATION 514
Assessing Left Ventricular Systolic Function 514

HEALTH PROMOTION AND COUNSELING: EVIDENCE AND RECOMMENDATIONS 516
Background 517
Screening for Hypertension 517
Initiating Statin Therapy for Primary Prevention 518
Promoting Lifestyle Changes and Risk Factor Modification 519
Addressing Excessive Dietary Sodium 521

REFERENCES 535

CHAPTER 19

Peripheral Vascular System 539

ANATOMY AND PHYSIOLOGY 539
Arterial System 539
Venous System 540
Lymphatic System 543
Transcapillary Fluid Exchange 545

HEALTH HISTORY: GENERAL APPROACH 545
Pain and/or Swelling of Legs with Intermittent Claudication 546
Pain and/or Swelling in Legs without Claudication 547
Abdominal, Flank, or Back Pain 548

PHYSICAL EXAMINATION: GENERAL APPROACH 549

TECHNIQUES OF EXAMINATION 550
Inspect the Upper Extremities 550
Palpate the Radial Pulse 551
Palpate the Brachial Pulse 551
Palpate for Epitrochlear Nodes 552
Examine the Abdominal Aorta 552
Palpate the Superficial Inguinal Nodes 552
Inspect the Lower Extremities 553
Assess the Temperature of the Feet and Legs 553
Palpate the Femoral Pulse 554
Palpate the Popliteal Pulse 554
Palpate the Posterior Tibial Pulse 555
Palpate the Dorsalis Pedis Pulse 556
Palpate for Pitting Edema 556
Palpate for Venous Tenderness or Cords 556

SPECIAL TECHNIQUES AND MANEUVERS 557
Assess for Peripheral Arterial Disease Using the Ankle–Brachial Index 557
Evaluate Arterial Perfusion of the Hand Using the Allen Test 558
Modifications in Physical Examinations: Best Practices for Specialized Patient Populations 558

RECORDING YOUR FINDINGS 562

POINT-OF-CARE ULTRASOUND EXAMINATION 563
Detecting Nonpalpable Pulses 563
Detecting Deep Venous Thrombosis 564

HEALTH PROMOTION AND COUNSELING: EVIDENCE AND RECOMMENDATIONS 567
Screening for Lower Extremity Peripheral Artery Disease 567
Screening for Abdominal Aortic Aneurysm 567

REFERENCES 576

CHAPTER 20

Breasts and Axillae 577

ANATOMY AND PHYSIOLOGY 577
Breast 577
Axilla 579

HEALTH HISTORY: GENERAL APPROACH 581
Breast Lump or Mass 581
Breast Discomfort or Pain 582
Nipple Discharge 583

PHYSICAL EXAMINATION: GENERAL APPROACH 584

TECHNIQUES OF EXAMINATION 585
Inspect the Breasts of Individuals Assigned Female at Birth in Four Views 585
Palpate the Breasts 588
Inspect the Axillae 591
Palpate the Axillary Lymph Nodes 591
Inspect the Breasts of Individuals Assigned Male at Birth 592

SPECIAL TECHNIQUES AND MANEUVERS 593
Modifications in Physical Examinations: Best Practices for Specialized Patient Populations 593

RECORDING YOUR FINDINGS 594

HEALTH PROMOTION AND COUNSELING: EVIDENCE AND RECOMMENDATIONS 595

Breast Cancer in Individuals Assigned Female at Birth 596
Breast Cancer in Individuals Assigned Male at Birth 599

REFERENCES 602

CHAPTER 21

Abdomen 603

ANATOMY AND PHYSIOLOGY 603

Abdominal Division Methods and Contents 603
Physiology of the Abdominal Organs 606

HEALTH HISTORY: GENERAL APPROACH 607

Abdominal Pain 608
Epigastric Pain 610
Right Upper Quadrant Abdominal Pain 611
Left Upper Quadrant Abdominal Pain 612
Right Lower Quadrant Abdominal Pain 613
Left Lower Quadrant Abdominal Pain 614
Hypogastric (Suprapubic) Pain 615
Nausea and Vomiting 616
Hematemesis 617
Hematochezia and Melena 618
Dysphagia and/or Odynophagia 619
Diarrhea 620
Constipation 621
Jaundice 622

PHYSICAL EXAMINATION: GENERAL APPROACH 625

TECHNIQUES OF EXAMINATION 626

Inspect the Abdomen 626
Auscultate for Bowel Sounds 626
Auscultate for Abdominal Bruits 628
Percuss the Abdomen 629
Palpate Lightly in All Four Abdominal Quadrants 630
Palpate Deeply in All Four Abdominal Quadrants 631
Estimate Liver Size by Percussion 632
Palpate the Liver Edge 633
Percuss for Splenic Enlargement 634
Palpate for the Splenic Edge 635
Palpate for Aortic Pulsations 637

SPECIAL TECHNIQUES AND MANEUVERS 638

Assessing Possible Peritonitis 638
Assessing Possible Ascites 639
Identifying Abdominal Organs and Masses in the Presence of Ascites 639
Assessing for Abdominal Wall Mass 640
Assessing Possible Appendicitis 640
Assessing Possible Acute Cholecystitis 641
Assessing Possible Renal Colic or Pyelonephritis 642
Assessing Ventral Hernias 642
Assessing for Urinary Bladder Distention 643
Modifications in Physical Examinations: Best Practices for Specialized Patient Populations 643

RECORDING YOUR FINDINGS 644

POINT-OF-CARE ULTRASOUND EXAMINATION 645

Ultrasound Technique 646
Assessing the Liver Size 646
Evaluating the Gallbladder 646
Evaluating for Intraperitoneal Free Fluid (FF) 648

HEALTH PROMOTION AND COUNSELING: EVIDENCE AND RECOMMENDATIONS 650

Viral Hepatitis A 651
Viral Hepatitis B 651
Viral Hepatitis C 652
Colorectal Cancer 653

REFERENCES 672

CHAPTER 22

Anus and Rectum 674

ANATOMY AND PHYSIOLOGY 674

HEALTH HISTORY: GENERAL APPROACH 675

Bloody Stool (Hematochezia) 676
Pain on Defecation 677
Anal and Perianal Lesions 678

PHYSICAL EXAMINATION: GENERAL APPROACH 679

TECHNIQUES OF EXAMINATION 679

Properly Position the Patient 679
Inspect the Sacrococcygeal and Perianal Areas 680
Inspect the Anus 680
Perform a Digital Rectal Examination 680

SPECIAL TECHNIQUES AND MANEUVERS 681

Perform a Prostatic Examination (When Indicated) 681
Perform a Rectovaginal Examination (When Indicated) 682

RECORDING YOUR FINDINGS 682

REFERENCES 686

CHAPTER 23

Pelvis and Genitourinary System: Penis, Scrotum, and Prostate 687

ANATOMY AND PHYSIOLOGY 687

Pelvis 687
Urogenital System 687
Prostate 690
Pelvic Floor Muscles 691
Groin or Inguinal Area 691
Blood, Lymphatic, and Nerve Supplies 692
Micturition Cycle 693
Sexual Development and Function 693

HEALTH HISTORY: GENERAL APPROACH 693

Lower Urinary Tract Storage Symptoms 694
Lower Urinary Tract Voiding Symptoms 695

Lower Urinary Tract Postmicturition Symptoms 696
Urinary Incontinence 697
Penile Discharge or Lesions 698
Scrotal or Testicular Pain, Swelling, or Lesions 699
Erectile Dysfunction 700

PHYSICAL EXAMINATION: GENERAL APPROACH 701

TECHNIQUES OF EXAMINATION 701
Inspect the Penile Skin, Prepuce, and Glans 701
Inspect the Urethral Meatus 702
Palpate the Shaft of the Penis 702
Inspect the Scrotum 702
Assess for Groin Hernias 703
Palpate Each Testis 703
Palpate the Epididymis 704
Examine the Spermatic Cord 704

SPECIAL TECHNIQUES AND MANEUVERS 704
Evaluating a Suspected Inguinal Hernia 705
Evaluating a Suspected Femoral Hernia 706
Assessing for Scrotal Contents by Transillumination 706
Performing a Testicular Self-Examination 706
Modifications in Physical Examinations: Best Practices for Specialized Patient Populations 707
Palpate the Posterior Surface of the Prostate Gland 710
Assess the Prostate's Size, Shape, Symmetry, Mobility, and Consistency 710

RECORDING YOUR FINDINGS 711

HEALTH PROMOTION AND COUNSELING: EVIDENCE AND RECOMMENDATIONS 712
Prostate Cancer 712

REFERENCES 725

CHAPTER **24**

Pelvis and Genitourinary System: Vulva, Vagina, Uterus, and Adnexa 727

ANATOMY AND PHYSIOLOGY 727
Pelvis 727
Pelvic Floor 729
Vulva 730
Vagina 731
Uterus 732
Cervix 732
Adnexa 733
Micturition Cycle 733
Menstrual Cycle 734
Menarche and Menses 735
Menopause 735

HEALTH HISTORY: GENERAL APPROACH 736
Painful Menstruation (Dysmenorrhea) 738
Absence of Menses (Amenorrhea) 739
Abnormal Uterine Bleeding 740
Pelvic Pain 741
Vulvovaginal Symptoms 742
Urinary Incontinence 743

PHYSICAL EXAMINATION: GENERAL APPROACH 744
Positioning 745
Prepare the Equipment 745

TECHNIQUES OF EXAMINATION 747
Assess Sexual Maturity (Adolescents) 748
Inspect the Vulva 748
Insert the Vaginal Speculum 748
Inspect the Cervix 749
Inspect the Vagina 750
Obtain Specimens for Cervical Cytology (Pap Smears) 750
Perform a Bimanual Examination 750
Assess the Pelvic Floor Muscles for Strength and Tenderness 752
Perform a Rectovaginal Examination (if Indicated) 753

SPECIAL TECHNIQUES AND MANEUVERS 754
Assessing Labial Swelling 754
Assessing for Urethritis 754
Assessing for Suspected Inguinal Hernia 754
Assessing for Suspected Femoral Hernia 755
Modifications in Physical Examinations: Best Practices for Specialized Patient Populations 755

RECORDING YOUR FINDINGS 755

POINT-OF-CARE ULTRASOUND EXAMINATION 757
Estimating Bladder Volume 757

HEALTH PROMOTION AND COUNSELING: EVIDENCE AND RECOMMENDATIONS 759
Cervical Cancer 759
Menopause and Hormone Replacement Therapy 760
Urinary Incontinence 761

REFERENCES 773

CHAPTER **25**

Musculoskeletal System: Neck, Shoulders, and Upper Extremities 775

ANATOMY AND PHYSIOLOGY: GENERAL MUSCULOSKELETAL SYSTEM 775
Vertebral Spine 775
Sacrococcygeal Spine 779
Joints 780

HEALTH HISTORY: GENERAL APPROACH 783
Musculoskeletal Problems 783

PHYSICAL EXAMINATION: GENERAL APPROACH 784
Inspection (Look) 785
Palpation (Feel) 785
Range of Motion (Move) 785
Special Maneuvers (Stress) 786

REGIONAL MUSCULOSKELETAL EXAMINATIONS 786

ANATOMY: TEMPOROMANDIBULAR JOINT 786

HEALTH HISTORY: GENERAL APPROACH 787
Jaw Pain 787

TECHNIQUES OF EXAMINATION 788
Inspect the Face and Temporomandibular Joint 789
Palpate the Temporomandibular Joint 789
Palpate the Muscles of Mastication 789
Assess Temporomandibular Joint Range of Motion 789

ANATOMY: CERVICAL SPINE (NECK) 790

HEALTH HISTORY: GENERAL APPROACH 791
Neck Pain or Stiffness 791

TECHNIQUES OF EXAMINATION 792
Inspect the Neck and Posture 792
Palpate the Muscles of the Neck 793
Palpate the Neck and Surrounding Structures 793
Assess Cervical Spine (Neck) Range of Motion 793
Perform Special Maneuvers for the Cervical Spine (If Indicated) 796

ANATOMY: SHOULDER 797

HEALTH HISTORY: GENERAL APPROACH 800
Shoulder Pain 800

TECHNIQUES OF EXAMINATION 801
Inspect the Shoulder and Associated Structures 801
Palpate the Shoulder and Associated Structures 802
Assess Shoulder Range of Motion 804
Perform Special Maneuvers for the Shoulder (If Indicated) 805

ANATOMY: ELBOW 809

HEALTH HISTORY: GENERAL APPROACH 810
Elbow Pain 810

TECHNIQUES OF EXAMINATION 811
Inspect the Elbow Joint 811
Palpate the Elbow Joint and Adjoining Structures 812
Assess Elbow Range of Motion 812
Perform Special Maneuvers for the Elbow Joint (If Indicated) 813

ANATOMY: WRIST AND HAND 814
Wrist Structure 814
Hand Structure 815

HEALTH HISTORY: GENERAL APPROACH 817
Wrist and Hand Pain 817

TECHNIQUES OF EXAMINATION 818
Inspect the Wrist 818
Inspect the Hand 819
Palpate the Wrist 819
Palpate the Hand 820
Assess Wrist, Fingers, and Thumb Range of Motion 822
Perform Special Maneuvers for the Wrist and Hand (If Indicated) 827

RECORDING YOUR FINDINGS 828

HEALTH PROMOTION AND COUNSELING: EVIDENCE AND RECOMMENDATIONS 829

REFERENCES 840

CHAPTER **26**
Musculoskeletal System: Lumbosacral Spine, Hips, and Lower Extremities 841

ANATOMY: LUMBOSACRAL SPINE 841

HEALTH HISTORY: GENERAL APPROACH 842

TECHNIQUES OF EXAMINATION 844
Observe the Gait 844
Observe the Pelvic Alignment 845
Palpate the Lumbosacral Spine and Adjoining Structures 845
Assess Lumbosacral Spine Range of Motion 846
Perform Special Maneuvers on the Lumbosacral Spine Joint (If Indicated) 847

ANATOMY: HIP JOINT 849

HEALTH HISTORY: GENERAL APPROACH 852

TECHNIQUES OF EXAMINATION 853
Inspect the Hip Joint 854
Palpate the Anterior Hip Landmarks 854
Palpate the Posterior Hip Landmarks 854
Assess Hip Joint Range of Motion 855
Perform Special Maneuvers on the Hip Joint (If Indicated) 858

ANATOMY: KNEE 859

HEALTH HISTORY: GENERAL APPROACH 864

TECHNIQUES OF EXAMINATION 866
Inspect the Gait 866
Inspect the Knee and Surrounding Structures 866
Palpate the Knee and Adjoining Structures 867
Assess Knee Range of Motion 869
Perform Special Maneuvers on the Knee Joint (If Indicated) 869

ANATOMY: ANKLE JOINT AND FOOT 871

HEALTH HISTORY: GENERAL APPROACH 872
Ankle Pain or Swelling 873
Foot Pain 873

TECHNIQUES OF EXAMINATION 874
Inspect the Ankle and Foot 875
Palpate the Ankle, Foot and Surrounding Structures 875
Assess Ankle and Foot Range of Motion 876
Perform Special Maneuvers on the Ankle and Foot (If Indicated) 877

SPECIAL TECHNIQUES AND MANEUVERS 879
Analyzing Gait 879
Measuring Leg Length 879
Describing Limited Joint Motion 881
Screening for Scoliosis 883
Detecting Knee Joint Effusions 883
Modifications in Physical Examinations: Best Practices for Specialized Patient Populations 885

RECORDING YOUR FINDINGS 885

POINT-OF-CARE ULTRASOUND EXAMINATION 889
Detecting Joint Fluid 889

HEALTH PROMOTION AND COUNSELING: EVIDENCE AND RECOMMENDATIONS 890
Osteoporosis: Burden of Disease and Risk Factors 890
Osteoporosis: Screening Recommendations 891
Osteoporosis: Assessing Fracture Risk 892
REFERENCES 897

CHAPTER 27

Nervous System 899

ANATOMY AND PHYSIOLOGY 899
Central Nervous System 899
Peripheral Nervous System 901
Motor Pathways 903
Spinal Reflexes: Muscle Stretch Response 905
Sensory Pathways 906
HEALTH HISTORY: GENERAL APPROACH 908
Headache 909
Dizziness or Lightheadedness 911
Weakness 912
Numbness or Abnormal or Absent Sensation 914
Fainting and Blacking Out (Near-Syncope and Syncope) 915
Seizures 916
Tremors or Involuntary Movements 917
PHYSICAL EXAMINATION: GENERAL APPROACH 918
TECHNIQUES OF EXAMINATION: MENTAL STATUS 919
Assess Mental Status 919
TECHNIQUES OF EXAMINATION: CRANIAL NERVES 921
Test for Cranial Nerve I—Olfactory 921
Test for Cranial Nerve II—Optic 921
Test for Cranial Nerves II and III—Optic and Oculomotor 922
Test for Cranial Nerves III, IV, and VI—Oculomotor, Trochlear, and Abducens 922
Test for Cranial Nerve V—Trigeminal 923
Test for Cranial Nerve VII—Facial 924
Test for Cranial Nerve VIII—Vestibulocochlear 924
Test for Cranial Nerves IX and X—Glossopharyngeal and Vagus 925
Test for Cranial Nerve XI—Spinal Accessory 925
Test for Cranial Nerve XII—Hypoglossal 926
TECHNIQUES OF EXAMINATION: MOTOR SYSTEM 926
Assess the Motor System for Body Position, Involuntary Movements, and Muscle Characteristics 927
Test Abduction at the Shoulder 931
Test Flexion and Extension at the Elbow 931
Test Flexion and Extension at the Wrist 932
Test Extension and Abduction of the Fingers 933
Test for Adduction and Abduction of the Thumb 934
Test Flexion and Extension at the Hips 934
Test Adduction and Abduction at the Hips 934
Test Flexion and Extension at the Knee 935
Test Dorsiflexion and Plantar Flexion of the Ankle 936
TECHNIQUES OF EXAMINATION: REFLEXES 937
Elicit the Biceps Reflex (C5, C6) 938
Elicit the Triceps Reflex (C6, C7) 938
Elicit the Brachioradialis Reflex (C5, C6) 939
Elicit the Quadriceps (Patellar) Reflex (L2–L4) 939
Elicit the Achilles (Ankle) Reflex (Primarily S1) 940
Test for Clonus (if indicated) 941
Assess Plantar Responses 942
Elicit Superficial Stimulation Reflex 942
TECHNIQUES OF EXAMINATION: SENSORY SYSTEM, COORDINATION, STATION, AND GAIT 943
Assess Sensation 943
Test Coordination (Rapid Alternating Movements) 947
Test Coordination (Point-to-Point Movements) 948
Perform Gait Assessment 948
Assess Station (Romberg Test) 949
SPECIAL TECHNIQUES AND MANEUVERS 949
Detecting Meningeal Irritation 949
Assessing for Lumbosacral Radiculopathy 951
Detecting Asterixis (Flapping Tremor) 952
Assessing Scapular Winging 952
Evaluating Neurologic Status in Comatose Patients 953
Modifications in Physical Examinations: Best Practices for Specialized Patient Populations 956
RECORDING YOUR FINDINGS 960
HEALTH PROMOTION AND COUNSELING: EVIDENCE AND RECOMMENDATIONS 962
Preventing Cerebrovascular Disease 962
Aspirin Chemoprophylaxis 963
Screening for Atrial Fibrillation 963
Screening for Asymptomatic Carotid Artery Stenosis 964
REFERENCES 992

UNIT 3

Special Populations 995

CHAPTER 28

Children: Infancy Through Adolescence 995

INTRODUCTION 995
GENERAL PRINCIPLES OF CHILD DEVELOPMENT 996
SURVEILLANCE OF DEVELOPMENT 997
KEY COMPONENTS OF HEALTH PROMOTION 998
NEWBORNS AND INFANTS 1000
HEALTH HISTORY: GENERAL APPROACH 1000
SURVEILLANCE OF DEVELOPMENT 1001

PHYSICAL EXAMINATION: GENERAL APPROACH 1004
Newborns 1004
Infants 1005
TECHNIQUES OF EXAMINATION: NEWBORNS AND INFANTS 1006
Apgar Score 1006
Gestational Age and Birth Weight 1006
General Survey 1010
Somatic Growth 1010
Vital Signs 1012
Skin 1014
Head 1018
Eyes 1021
Ears 1023
Nose 1023
Mouth and Pharynx 1024
Neck 1025
Thorax and Lungs 1026
Heart 1028
Peripheral Vascular System 1031
Breasts 1033
Abdomen 1033
Penis, Testes, and Scrotum 1034
Vulva and Vagina 1035
Rectum and Anus 1036
Musculoskeletal System 1036
Nervous System 1039
RECORDING YOUR FINDINGS 1044
HEALTH PROMOTION AND COUNSELING: EVIDENCE AND RECOMMENDATIONS 1044
***PRESCHOOL-AGE AND SCHOOL-AGE CHILDREN* 1046**
HEALTH HISTORY: GENERAL APPROACH 1046
SURVEILLANCE OF DEVELOPMENT: EARLY CHILDHOOD, 1 TO 4 YEARS 1048
SURVEILLANCE OF DEVELOPMENT: MIDDLE CHILDHOOD, 5 TO 10 YEARS 1049
PHYSICAL EXAMINATION: GENERAL APPROACH 1050
TECHNIQUES OF EXAMINATION 1052
Somatic Growth 1053
Vital Signs 1054
Skin 1057
Head 1057
Eyes 1057
Ears 1058
Nose and Sinuses 1062
Mouth and Pharynx 1063
Neck 1065
Thorax and Lungs 1066
Heart and Vascular System 1067
Abdomen 1069
Penis and Scrotum 1070
Vulva and Surrounding Structures 1071
Rectum and Anus 1074
Musculoskeletal System 1074
Nervous System 1076
RECORDING YOUR FINDINGS 1077
HEALTH PROMOTION AND COUNSELING: EVIDENCE AND RECOMMENDATIONS 1083
Children 1 to 4 Years 1083
Children 5 to 10 Years 1084
***ADOLESCENTS* 1085**
HEALTH HISTORY: GENERAL APPROACH 1085
HEEADSSS Assessment 1086
SURVEILLANCE OF DEVELOPMENT: 11 TO 20 YEARS 1087
Gender and Sexual Identity Formation among Adolescents 1089
PHYSICAL EXAMINATION: GENERAL APPROACH 1089
TECHNIQUES OF EXAMINATION 1090
SPECIAL TECHNIQUES AND MANEUVERS 1097
Assessing for Scoliosis 1097
Conducting Sports Preparticipation Physical Evaluation 1098
RECORDING YOUR FINDINGS 1100
HEALTH PROMOTION AND COUNSELING: EVIDENCE AND RECOMMENDATIONS 1100
REFERENCES 1118

CHAPTER 29

Pregnant Persons 1121

ANATOMY AND PHYSIOLOGY 1121
Anatomic Changes 1121
Physiologic Hormonal Changes 1123
HEALTH HISTORY: GENERAL APPROACH 1125
Initial Prenatal Visit 1125
Subsequent Prenatal Visits 1129
PHYSICAL EXAMINATION: GENERAL APPROACH 1129
TECHNIQUES OF EXAMINATION 1130
Position the Pregnant Individual 1130
Prepare the Examining Equipment 1131
Conduct a General Inspection 1131
Measure Height, Weight, and Vital Signs 1131
Inspect the Head and Neck 1132
Inspect, Percuss, and Auscultate the Thorax and Lungs 1132
Examine the Heart 1132
Examine the Breasts 1132
Examine the Abdomen 1133
Examine the External Genitalia 1134
Inspect the Internal Genitalia 1135
Examine the Internal Genitalia 1135
Consider Examining the Anus, Rectum, and Rectovaginal Septum 1136
Examine the Extremities 1136

SPECIAL TECHNIQUES 1137
Leopold Maneuvers 1137
RECORDING YOUR FINDINGS 1139
HEALTH PROMOTION AND COUNSELING: EVIDENCE AND RECOMMENDATIONS 1140
Screening for Infectious Diseases 1140
Genetic Testing and Aneuploidy Screening 1142
Screening for Medical Conditions Associated with Pregnancy 1142
Screening for Perinatal Depression 1144
Intimate Partner Violence Screening 1145
Rh(D) Incompatibility Screening 1146
Screening and Counseling for Unhealthy Behaviors 1146
Counseling for Healthy Weight and Weight Gain in Pregnancy 1147
Interventions to Prevent Perinatal Depression 1148
Breastfeeding or Chestfeeding 1148
Immunizations in Pregnancy 1149
Preventive Medications 1149
Unintended Pregnancy 1150
REFERENCES 1155

CHAPTER 30
Older Adults 1158
ADDRESSING THE CHALLENGES OF GLOBAL AGING 1158
DEFINING OLDER ADULTHOOD 1159
ANATOMIC AND PHYSIOLOGIC CHANGES IN OLDER ADULTS 1159
COMMUNICATING EFFECTIVELY WITH OLDER ADULTS 1162
GERIATRIC 5Ms 1164
HEALTH HISTORY: APPLYING THE 5Ms FRAMEWORK 1164
Mind 1164
Mobility 1165
Medications 1166
Multicomplexity 1168
Matters Most 1168
ADJUSTMENTS IN PHYSICAL EXAMINATION TECHNIQUES FOR OLDER ADULTS 1170
GERIATRIC ASSESSMENT: APPLYING THE 5Ms FRAMEWORK 1173
Mind 1173
Mobility 1175
Medications 1178
Multicomplexity 1179
Matters Most 1180
HEALTH PROMOTION AND COUNSELING: EVIDENCE AND RECOMMENDATIONS 1183
When to Screen 1183
Immunizations 1184
Cancer Screening 1185
Elder Abuse 1187
Household Safety and Falls Prevention 1189
REFERENCES 1190

Index 1195

List of Tables

CHAPTER 6 **Clinical Documentation and Oral Presentation 95**

Table 6-1: Special Considerations in Clinical Documentation 113

CHAPTER 11 **Cognition, Behavior, and Mental Status 197**

Table 11-1: Central Nervous System Structures and Mental Disorders 223
Table 11-2: Neurocircuitry of Mental Disorders 225
Table 11-3: Neurocognitive Disorders: Delirium and Dementia 226
Table 11-4: Somatic Symptom and Related Disorders 227
Table 11-5: Screening for Depression: Geriatric Depression Scale (Short Form) 228
Table 11-6: Screening for Depression: Patient Health Questionnaire (PHQ-9) 229
Table 11-7: Screening for Anxiety Disorders: GAD-7 231
Table 11-8: Screening for Dementia: Mini-Cog 232
Table 11-9: Screening for Dementia: Montreal Cognitive Assessment (MoCA) 233
Table 11-10: Screening for Cognitive Impairment and Dementia: Saint Louis University Mental Status Exam (SLUMS) 234

CHAPTER 12 **Skin, Hair, and Nails 239**

Table 12-1: Describing Primary Skin Lesions: Flat, Raised, and Fluid-Filled 271
Table 12-2: Additional Primary Lesions: Pustules, Furuncles, Nodules, Cysts, Wheals, Burrows 275
Table 12-3: Dermatology Safari: Benign Lesions 277
Table 12-4: Rough Lesions: Actinic Keratoses, Squamous Cell Carcinoma, and their Mimics 278
Table 12-5: Pink Lesions: Basal Cell Carcinoma and Its Mimics 279
Table 12-6: Brown Lesions: Melanoma and Its Mimics 281
Table 12-7: Vascular and Purpuric Lesions of the Skin 285
Table 12-8: Hair Loss 287
Table 12-9: Findings in or Near the Nails 290
Table 12-10: Systemic Diseases and Associated Skin Findings 292
Table 12-11: Acne Vulgaris—Primary and Secondary Lesions 294
Table 12-12: Signs of Sun Damage 295
Table 12-13: Pressure Injuries 296

CHAPTER 13 **Head and Neck 300**

Table 13-1: Symptoms and Signs of Thyroid Dysfunction 316
Table 13-2: Thyroid Enlargement and Function 317

CHAPTER 14 **Eyes 319**

Table 14-1: Red Eyes 346
Table 14-2: Visual Field Defects 348
Table 14-3: Variations and Abnormalities of the Eyelids 349
Table 14-4: Lumps and Swellings in and Around the Eyes 350
Table 14-5: Opacities of the Cornea and Lens 351
Table 14-6: Pupillary Abnormalities 352
Table 14-7: Dysconjugate Gaze 353

Table 14-8: Normal Variations of the Optic Disc 354
Table 14-9: Abnormalities of the Optic Disc 355
Table 14-10: Retinal Arteries and Arteriovenous Crossings: Normal and Hypertensive 356
Table 14-11: Red Spots and Streaks in the Fundi 357
Table 14-12: Light-Colored Spots in the Fundi 358

CHAPTER 15 Ears and Nose 360

Table 15-1: Dizziness and Vertigo 384
Table 15-2: Lumps on or Near the Ear 385
Table 15-3: Abnormalities of the Tympanic Membrane 386
Table 15-4: Patterns of Hearing Loss 388

CHAPTER 16 Throat and Oral Cavity 390

Table 16-1: Abnormalities of the Lips 406
Table 16-2: Findings in the Pharynx, Palate, and Oral Mucosa 408
Table 16-3: Findings in the Gums and Teeth 412
Table 16-4: Findings in or under the Tongue 414

CHAPTER 17 Thorax and Lungs 417

Table 17-1: Normal and Altered Breath and Voice Sounds 455
Table 17-2: Dyspnea 456
Table 17-3: Cough and Hemoptysis 460
Table 17-4: Chest Pain 462
Table 17-5: Abnormalities in Rate and Rhythm of Breathing 464
Table 17-6: Deformities of the Thorax 465
Table 17-7: Adventitious (Added) Lung Sounds: Causes and Qualities 466
Table 17-8: Physical Findings in Selected Chest Disorders 468

CHAPTER 18 Cardiovascular System 472

Table 18-1: Selected Heart Rates and Rhythms 522
Table 18-2: Selected Irregular Rhythms 523
Table 18-3: Abnormalities of the Arterial Pulse and Pressure Waves 524
Table 18-4: Variations and Abnormalities of the Ventricular Impulses 525
Table 18-5: Variations in the First Heart Sound—S_1 526
Table 18-6: Variations in the Second Heart Sound—S_2 527
Table 18-7: Extra Heart Sounds in Systole 528
Table 18-8: Extra Heart Sounds in Diastole 529
Table 18-9: Midsystolic Murmurs 530
Table 18-10: Pansystolic (Holosystolic) Murmurs 532
Table 18-11: Diastolic Murmurs 533
Table 18-12: Cardiovascular Sounds with Both Systolic and Diastolic Components 534

CHAPTER 19 Peripheral Vascular System 539

Table 19-1: Types of Peripheral Edema 569
Table 19-2: Painful Peripheral Vascular Disorders and Their Mimics 570
Table 19-3: Chronic Insufficiency of Arteries and Veins 574
Table 19-4: Common Ulcers of the Ankles and Feet 575

CHAPTER 20 Breasts and Axillae 577

Table 20-1: Common Breast Masses 600
Table 20-2: Visible Signs of Breast Cancer 601

CHAPTER 21 Abdomen 603

Table 21-1: Classification and Diagnosis of Selected Functional Gastrointestinal Disorders 655
Table 21-2: Abdominal Pain 656
Table 21-3: Dysphagia 660
Table 21-4: Diarrhea 661
Table 21-5: Constipation 664
Table 21-6: Black and Bloody Stool 665
Table 21-7: Localized Bulges in the Abdominal Wall 666
Table 21-8: Protuberant Abdomens 667
Table 21-9: Sounds in the Abdomen 668
Table 21-10: Tender Abdomens 669
Table 21-11: Liver Enlargement: Apparent and Real 671

CHAPTER 22 Anus and Rectum 674

Table 22-1: Abnormalities of the Anus, Surrounding Skin, and Rectum 684

CHAPTER 23 Pelvis and Genitourinary System: Penis, Scrotum, and Prostate 687

Table 23-1: Urinary Frequency, Nocturia, and Polyuria 714
Table 23-2: Urinary Incontinence in Individuals Assigned Male at Birth 716
Table 23-3: Sexually Transmitted Infection–Associated Changes in Genital Anatomy 718
Table 23-4: Abnormalities of the Penis and Scrotum 719
Table 23-5: Abnormalities of the Testis 720
Table 23-6: Abnormalities of the Epididymis and Spermatic Cord 721
Table 23-7: Course, Presentation, and Differentiation of Hernias in the Groin 722
Table 23-8: BPH Symptom Score: American Urological Association 723
Table 23-9: Abnormalities of the Prostate 724

CHAPTER 24 Pelvis and Genitourinary System: Vulva, Vagina, Uterus, and Adnexa 727

Table 24-1: Bulges and Swelling of the Vulva, Vagina, and Urethra 764
Table 24-2: Lesions of the Vulva 765
Table 24-3: Vaginal Discharge 766
Table 24-4: Urinary Incontinence in Individuals Assigned Female at Birth 767
Table 24-5: Variations in the Cervical Surface 768
Table 24-6: Shapes of the Cervical Os 769
Table 24-7: Abnormalities of the Cervix 769
Table 24-8: Positions of the Uterus Retroversion and Retroflexion Are Usually Normal Variants 770
Table 24-9: Abnormalities of the Uterus 771
Table 24-10: Adnexal Masses 772

CHAPTER 25 Musculoskeletal System: Neck, Shoulders, and Upper Extremities 775

Table 25-1: Patterns of Pain in and Around the Joints 830
Table 25-2: Systemic Manifestations of Musculoskeletal Disorders 832
Table 25-3: Pains in the Neck 833
Table 25-4: Painful Shoulders 834
Table 25-5: Swollen or Tender Elbows 836
Table 25-6: Arthritis in the Hands 837
Table 25-7: Swellings and Deformities of the Hands 838
Table 25-8: Tendon Sheath, Palmar Space, and Finger Infections 839

CHAPTER **26** **Musculoskeletal System: Lumbosacral Spine, Hips, and Lower Extremities 841**

Table 26-1: Low Back Pain 893
Table 26-2: Abnormalities of the Feet 895
Table 26-3: Abnormalities of the Toes and Soles 896

CHAPTER **27** **Nervous System 899**

Table 27-1: Disorders of the Central and Peripheral Nervous Systems 965
Table 27-2: Disorders of Speech 968
Table 27-3: Abnormalities of Gait and Posture 969
Table 27-4: Primary Headaches 970
Table 27-5: Secondary Headaches and Cranial Neuralgias 972
Table 27-6: Syncope and Similar Disorders 976
Table 27-7: Types of Stroke 978
Table 27-8: Seizure Disorders 980
Table 27-9: Tremors and Involuntary Movements 982
Table 27-10: Nystagmus 984
Table 27-11: Types of Facial Paralysis 986
Table 27-12: Abnormal Body Postures 987
Table 27-13: Disorders of Muscle Tone 988
Table 27-14: Glasgow Coma Scale 989
Table 27-15: Metabolic and Structural Coma 990
Table 27-16: Pupils in Comatose Patients 991

CHAPTER **28** **Children: Infancy Through Adolescence 995**

Table 28-1: Abnormalities in Heart Rhythm 1102
Table 28-2: Abnormalities in Blood Pressure 1102
Table 28-3: Common Skin Rashes and Skin Findings in Newborns and Infants 1103
Table 28-4: Warts and Lesions that Resemble Warts, and Other Raised Lesions 1104
Table 28-5: Common Skin Lesions during Childhood 1105
Table 28-6: Abnormalities of the Head 1106
Table 28-7: Diagnostic Facies in Infancy and Childhood 1107
Table 28-8: Abnormalities of the Eyes, Ears, and Mouth 1109
Table 28-9: Abnormalities of the Teeth, Pharynx, and Neck 1110
Table 28-10: Cyanosis in Children 1111
Table 28-11: Congenital Heart Murmurs 1112
Table 28-12: Common Abnormalities in the Genitourinary Anatomy Associated with Testes and Penises 1115
Table 28-13: Common Musculoskeletal Findings in Young Children 1115
Table 28-14: Power of Prevention: Vaccine-Preventable Diseases 1116

CHAPTER **29** **Pregnant Persons 1121**

Table 29-1: Normal Anatomic and Physiologic Changes in Pregnancy 1152

UNIT 1

Foundations of Health Assessment

CHAPTER 1

Foundational Skills Essential to the Clinical Encounter

> *"The ritual of one individual coming to another and telling [them] things that [they] would not tell [their] preacher or rabbi; and then, incredibly, on top of that, disrobing and allowing touch…I think our skills in examining a patient have to be worthy of that kind of trust."*
>
> —Abraham Verghese, MD, A Doctor's Touch, TEDGlobal, 2011.

THE CLINICAL ENCOUNTER

As you begin your clinical training, you'll learn a range of essential skills that will deepen your patient relationships and enhance your ability to provide care. A *clinical skill* is any discrete act within the overall process of patient care.[1] Clinical skills are the singular elements that constitute clinical competence. Through the purposeful selection and integration of these individual skillful acts during the patient encounter, you will lay the foundation for high-quality clinical care.

Your clinical skills will evolve over time as you develop your professional relationship with each patient, take their clinical history, perform a mental and physical examination, conduct tests and procedures, and provide diagnostic and therapeutic interventions.[2] To become a skilled clinician, you will need to integrate contemporary biomedical knowledge into your patient care in a professional and culturally sensitive manner.[2] As a student, you will gradually move from passive observation to active patient assessment, gaining confidence and expertise with each encounter. You will also need to commit to ongoing practice and honest self-assessment in order to continuously improve your skills.

The initial chapters in this unit will introduce you to the essentials of the clinical encounter, with a focus on establishing trust, which is the foundation of the therapeutic alliance with patients (Fig. 1-1). Initially, you will focus on gathering information, but with experience and empathic listening, you will learn to allow the patient's story to unfold in its most authentic and detailed form. By mastering these skills and building caring patient relationships based on mutual trust and respect, you will reap the timeless rewards of the clinical professions. These are the fundamental features of all clinical care.[2]

Chapter Content Guide

- Approach to the Clinical Encounter
- Structure and Sequence of the Clinical Encounter
- Disparities in Health Care
- Other Major Considerations

FIGURE 1-1. Therapeutic alliance between clinician and patient.

APPROACH TO THE CLINICAL ENCOUNTER

The clinical encounter involves both the clinician and the patient and can be approached in two ways: *clinician-centered* and *patient-centered*. The former approach prioritizes acquiring details about symptoms and disease, potentially neglecting the personal dimensions of illness.[3,4] In contrast, the patient-centered approach values patients' expressions of personal concerns and emotions and considers the patient's perspective of illness.

The *disease/illness distinction model* helps to clarify the distinct but complementary perspectives of the clinician and the patient (Box 1-1).[5] A successful clinical interview must incorporate both the clinician's and the patient's perspectives of reality, disease, and illness.[3]

Research indicates that integrating both clinician-centered and patient-centered approaches in a clinical encounter leads to a more comprehensive understanding of the patient's illness and enables clinicians to convey qualities of respect, empathy, humility, and sensitivity.[3,7] This merged approach has been shown to be more satisfying for both patients and clinicians and more effective in achieving desired health outcomes.[8,9] By incorporating both perspectives in your clinical encounters, you can gain a more well-rounded view of the patient's problems from both your own and their point of view. Achieving a balance between these two essential components is critical for conducting an effective clinical interview in a patient encounter.

Box 1-1. Disease/Illness Distinction Model

Disease	Explanation used by the clinician to organize symptoms, leading to a clinical diagnosis
Illness	Construct that explains how the patient experiences the disease, including its impact on relationships, function, and overall well-being

For example, when a patient presents with a sore throat, the clinician may focus on identifying the cause of the symptoms, such as streptococcal pharyngitis or allergies to penicillin. However, the patient's concerns may extend beyond the physical symptoms to include worries about pain, difficulty swallowing, missing work, or even the fear of developing cancer.

These divergent concerns illustrate the importance of incorporating both the clinician's and the patient's perspectives into the clinical interview.[3,6]

STRUCTURE AND SEQUENCE OF THE CLINICAL ENCOUNTER

In general, an effective clinical encounter moves through a logical sequence (Box 1-2).[10] In this chapter, we focus on the behaviors related to the initiation and closure of the clinical encounter as well as the exploration of the patient's perspectives of their illness. An illustrative example of this framework is the enhanced *Calgary–Cambridge Guides* (Fig. 1-2), which describes the structure and timeline of the clinical encounter and highlight the need to elicit information regarding both the biomedical disease process and the patient's perspective. They also include a place for the physical examination. The structure includes five major steps: *initiating the session*, *information gathering*, *physical examination*, *explaining and planning*, and *closing the session*.[11–13]

Box 1-2. General Structure and Sequence of the Clinical Encounter

1. Initiating the encounter
   - Setting the stage/preparation
   - Greeting the patient and establishing initial rapport
2. Gathering information
   - Initiating information gathering
   - Exploring patient's perspective of illness
   - Exploring biomedical perspective of disease including relevant background and context
3. Performing the physical examination
4. Explaining and planning
   - Provide correct amount and type of information
   - Negotiate plan of action
   - Shared decision making
5. Closing the encounter

Note: Two additional frameworks occur as continuous threads throughout the sequence—namely, building the relationship and structuring the interview (see Fig. 1-2).

Source: Adapted from Kurtz S, Silverman J, Benson J, Draper J. Marrying content and process in clinical method teaching: enhancing the Calgary–Cambridge guides. *Acad Med*. 2003;78(8):802–809; van de Poel K, Vanagt E, Schrimpf U, Gasiorek J. *Communication Skills for Foreign and Mobile Medical Professionals*. Springer; 2013:xvii, 145; de Haes H, Bensing J. Endpoints in medical communication research, proposing a framework of functions and outcomes. *Patient Educ Couns*. 2009;74(3):287–294.

STRUCTURE AND SEQUENCE OF THE CLINICAL ENCOUNTER

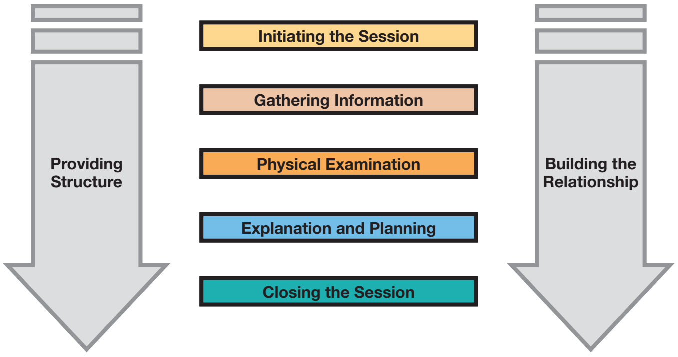

FIGURE 1-2. Enhanced Calgary–Cambridge Guides: Structure and timeline of the clinical encounter. (Reproduced with permission from Kurtz S, Silverman J, Benson J, Draper J. Marrying content and process in clinical method teaching: enhancing the Calgary–Cambridge guides. *Acad Med*. 2003;78[8]:802–809.)

Stage 1: Initiating the Encounter

This is the stage of relationship-building with your patient. Fostering the patient–clinician relationship is critical because without a good relationship, none of the other goals of the clinical encounter can be pursued in an optimal manner.[14] Respect, trust, and rapport are necessary components of a burgeoning therapeutic relationship.

Set the Stage. To start, set the stage and prepare for the interview. Check your appearance, make sure the patient is comfortable, and create an environment that is conducive to sharing personal information. Each interview has its own rhythm and sequence, so mastering the steps described is essential. Also, reflect on any biases you may have that could color your reactions to the patient and the therapeutic alliance you need to create. See Racism and Bias, p. 11.

Adjust the Environment. Adjust the environment to ensure effective communication with your patient. Even in challenging settings like a two-bedded hospital room or a busy emergency department, improving communication is worth the effort. Use privacy curtains or move to an empty room to create a more confidential setting.

Consider factors like cultural background and individual preferences about interpersonal space. Choose a distance that allows for good eye contact and clear conversation, pull up a chair, and sit at eye level with the patient to facilitate communication. Move any physical barriers out of the way to create an open and welcoming environment (Fig. 1-3).

Be mindful of arrangements that may convey disrespect, such as interviewing a patient who is already positioned for a pelvic exam or talking through a bathroom door. Ensure that any computer monitors are positioned so as not to obstruct your view of the patient or hide your face from them. Lighting is another essential consideration. Create a private and welcoming environment to help facilitate effective communication and build a positive rapport with your patient.

FIGURE 1-3. Move physical barriers out of the way and be at eye level.

Review the Clinical Record. Before seeing the patient, review the clinical record (Fig. 1-4). It will provide important background information and suggest areas to explore during the visit. Review identifying data such as age, gender, address, and insurance as well as the Patient Problem List, medications, and allergies.

The clinical record usually contains past diagnoses and treatments, but making your assessment based on what you learn during the visit is important. Keep in mind that the clinical record is compiled from many observers,

FIGURE 1-4. Review the health record before the clinical encounter.

and data may be incomplete or even contradict what the patient tells you. Reconcile any discrepancies in the record for the patient's care. Be aware of potential problems that may arise from documentation mismatches, especially as electronic health records are being developed to include preferred names and gender pronouns. Address any issues related to this or other sensitive topics that may arise during the visit. Being thorough in your review of the clinical record allows you to provide the best possible care for your patient.

Set Your Agenda. Before speaking with the patient, clarify your goals for the interview. A student goal may be completing a comprehensive history, whereas for an advanced trainee or clinician, goals range from assessing a new concern to treatment follow-up. Regardless, balancing clinician-centered and patient-centered goals is essential, as is considering the agendas of the patient, their family, and health care agencies. Taking a few minutes to think about your goals will help you align your priorities with the patient's agenda.[15]

Greet the Patient and Establish Initial Rapport. The initial moments of your encounter lay the foundation for your ongoing relationship. How you greet the patient and other visitors in the room, provide for the patient's comfort, and arrange the physical setting, all shape the patient's first impressions (Fig. 1-5). Relating effectively with patients is among the most valued skills of clinical care. For the patient, "a feeling of connectedness . . . of being deeply heard and understood . . . is the very heart of healing."[16] For the clinician, this deeper relationship enriches the rewards of patient care.[17–19] Suggestions on how to establish rapport with specific patient populations are shown in Box 1-3.

As you begin, *welcome the patient by introducing yourself,* giving your own first and last name. If possible, shake hands with the patient. If this is the first time you are seeing the patient, explain your role, your status as a student or trainee, and how you will be involved in their care.

FIGURE 1-5. Greeting the patient and establishing rapport.

Identify Preferred Title, Name and Pronouns. As much as possible, let the patient dictate how they would like to be addressed (Box 1-6). Clinicians should ask all patients their *preferred titles*, *preferred name*, and *pronouns*, ideally at the beginning of the visit and/or on an intake questionnaire.

Preferred Title. Titles include Mr., Mrs., Ms., or honorifics such as Professor or Doctor. This not only provides valuable information about the patient's identity but is also important in establishing rapport and showing respect, especially if you are seeing the patient for the first time and promotes a welcoming environment.

Preferred Name. The name may be a nickname (e.g., "Pat" for "Patrick"), use of a middle name, or some other name altogether. After stating your name, ask the patient what name they would like you to use. Except with children or adolescents, avoid first names until you have specific permission. Calling a patient *"dear," "sweetie,"* or overly familiar names can depersonalize and demean them.[21]

If you are unsure how to pronounce the patient's name, do not be afraid to ask. You can say, "*I am afraid of mispronouncing your name. Could you say it for me?*" Then repeat it to make sure you heard it correctly. For patients who identify as transgender and gender nonbinary, the preferred name may match their affirmed gender and be different than their given name, which may have matched their sex assigned at birth.[20]

Pronouns. When asking patients about their pronouns, it can be helpful to share your own pronouns with patients, asking: *"Which gender pronouns do you use?"* (Box 1-7). For example, *"I use . . . he and him/she and hers/they and theirs."* Some of your patients may use *gender-neutral pronouns* or *inclusive pronouns.* These are pronouns that are not associated with a particular gender. They are used by individuals who do not identify as strictly male or female or who prefer not to be referred to as he/him or she/her. Some examples include *they/them, ze/hir, xe/xem,* and *ey/em.* These pronouns are used to promote inclusivity and respect for individuals who identify outside of the gender binary.

To show respect and avoid making patients feel disrespected or invalidated, it's crucial to use the correct title, name, and pronoun they have provided. Misgendering

Box 1-3. Approach to Establishing Rapport with Specific Populations

Population	Recommendations
Newborns and Infants (birth to 30 days; 1 month to 1 year) 	■ Building rapport is still important even though newborns and infants are unable to communicate like older children. ■ Congratulate the family on their newborn, encourage caregivers to feed the newborn either while talking or before the encounter to keep the newborn calm, and focus on the caregivers to ask about their well-being. ■ Take advantage of opportunities to obtain quick screening questions about family health topics.
Young and School-Age Children (1 to 4 years; 5 to 10 years)[22–25] 	■ To begin the encounter with a child patient and their family, introduce yourself first, then engage the child with play to build rapport and manage their mood. ■ While the child is playing, obtain the health history from the caregiver, asking for confirmation or elaboration as necessary. ■ For school-age children, familiarize yourself with "kid culture" and ask age-appropriate questions to facilitate engagement.
Adolescents[26–28] 	■ When interacting with adolescent patients, prioritize their confidentiality and trust while ensuring family members and caregivers feel comfortable and heard. ■ Use open-ended questions, provide ample opportunities for adolescents to share their concerns, and acknowledge the importance of their privacy. ■ Inform the family that they will have an opportunity to speak with you but first spend time alone with the adolescent patient without any family members present.
Older Adults[21] 	■ When interacting with older adult patients, elicit their preferred way of being addressed and adjust the environment to put them at ease. ■ Provide a well-lit, moderately warm setting with minimal background noise, chairs with arms, and ample space for safe navigation, particularly if using an assistive device. ■ Allow time for open-ended questions, reminiscing, and include family and caregivers, especially when cognitive impairment is present.
Patients with Physical and Sensory Disabilities 	■ When referring to patients with disabilities, use "people-first" language (e.g., *person who is blind, person who uses a wheelchair, person with hearing loss*) unless they specify otherwise. ■ Always presume that patients with physical and/or sensory disabilities are competent to manage their medical care and avoid making assumptions about what assistance they may require. ■ Speak directly with the patient, not to an aide or companion, and refrain from asking whether they are accompanied if they entered the room alone (Box 1-4).
Lesbian, Gay, Bisexual, Transgender, Queer + (LGBTQ+) Adults[29–32] 	■ When working with LGBTQ+ patients, recognize that they may experience anxiety related to acceptance and discomfort in disclosing their sexual behaviors and identity. ■ Expand your knowledge and clinical skills in gay, lesbian, and transgender health and engage with available resources. ■ Prepare to answer questions about fertility and transgender issues such as hormonal therapy and gender-affirming procedures and be open to discussing these topics with patients (Box 1-5).

Box 1-4. Establishing Rapport with Patients with Physical and Sensory Disabilities

- Based on 2023 global population estimates, more than 1.3 billion people (16% of the world's population) are estimated to live with some form of disability.[89]
- In the United States, the overall rate of people with disabilities in 2021 was estimated as 13.5% of the population.[90]

Patients Who Are Blind or Have Low Vision

- Always verbally identify yourself when you approach and introduce other people in the room.
- Do not leave without letting the patient know.
- Ask before you help. Always ask how the patient would like to be assisted.
- Be prepared to provide written materials in an auditory, tactile, or electronic format of the patient's preference (audio file, Braille, large print).
- Explain what is about to happen before beginning the encounter and ask if the patient has any questions.
- Tell the patient where personal effects (clothes and other belongings) are in the room and do not move them without telling the patient.
- Staff should be welcoming and describe the physical environment (doors, steps, ramps, bathroom location, etc.).
- Never distract or touch a service animal without asking the owner.

Patients Who Are Hard of Hearing

- Ask how best to communicate.
- Be prepared to give written materials as long as they are not the primary form of communication.
- Inform patients that sign language interpreting and real-time captioning services are available.
- If requested, promptly provide sign language interpreting or real-time captioning service for effective communication.
- Do not talk at a distance from the patient or from another room.
- Look directly at the patient when speaking so your mouth is visible.
- Speak normally and clearly. Do not shout, exaggerate mouth movements, or speak rapidly.
- Minimize background noise and glare.

Patients Who Are Deaf

- Ask how best to communicate.
- Inform patients that sign language interpreting and real-time captioning services are available.
- If requested, promptly provide sign language interpreting or real-time captioning service for effective communication.
- Do not use family members to interpret.
- Address the patient, not the interpreter.
- Be prepared to give written materials as long as they are not the primary form of communication.

Patients Who Use Wheelchairs

- Make sure there is a path of access to the room.
- Respect personal space, including wheelchair and assistive devices.
- Do not propel the wheelchair unless asked to do so.
- Provide accessible equipment as needed.
- Assist as needed, such as by clearing obstacles from the path of travel or helping patients transfer to equipment if accessible equipment is unavailable.
- Do not separate patients from their wheelchairs.

Source: Reprinted with permission from Access to Medical Care: Adults with Physical Disabilities (Project Director: Marsha Saxton, PhD). World Institute on Disability; 2016. Accessed June 16, 2023. https://worldinstituteondisabilityblog.files.wordpress.com/2016/01/access-to-medical-care-curriculum-pdf-format.pdf

Box 1-5. Lesbian, Gay, Bisexual, and Transgender Health

Several recent surveys provide some of the first national data sets on the lesbian, gay, bisexual, and transgender (LGBT) population.

- For the first time, in 2013, the National Health Interview Survey included a measure of sexual orientation: in the 2018 report, a sample of around 27,000 adults, 1.6% identified as gay or lesbian, 1.0% identified as bisexual, and 1.6% responded either other or did not know. Most gay and lesbian respondents were ages 18 to 44 years, with a higher percentage of bisexual respondents ages 18 to 44 years.[91]
- In 2012, the Gallup Daily Tracking Survey initiated the largest single study of the distribution of the LGBT population in the United States.[92,93] The Survey added an LGBT identity question that generated 120,000 responses: 3.4% answered “yes” when asked if they identify as LGBT. Of those identifying as LGBT, 53% were female and 6.4% were ages 18 to 29 years. Nearly 13% were in a domestic partnership or living with a partner. Non-Whites were more likely to identify as LGBT: African American 4.6%, Asians 4.3%, Hispanics 4.9%, and non-Hispanic White 3.2%.
- The 2013 American Community Survey of the United States Census Bureau reported more than 726,000 same-sex couple households; 34% had same-sex spouses.[94]
- In its 2011 report on LGBT health disparities, the Institute of Medicine called for better measures of health care disparities among the diverse LGBT subpopulations to elucidate their differing health behaviors and health care needs.[95]
- LGBT patients have higher rates of depression, suicide, anxiety, drug use, sexual victimization, and risk of infection with HIV and sexually transmitted infections.[96,97]
- One-third (33%) of transgender individuals who saw a health care provider in the past year reported having at least one negative experience related to being transgender, such as “*being refused treatment, verbally harassed, or physically or sexually assaulted, or having to teach the provider about transgender people in order to get appropriate care, with higher rates for people of color and people with disabilities.*”[98]
- The Institute of Medicine has stated that barriers to accessing quality health care for LGBT adults are “a lack of providers who are knowledgeable about LGBT health needs as well as a fear of discrimination in health care settings.”[95]

a patient can lead to feelings of alienation, dysphoria, or disrespect. While it’s not always possible to avoid mistakes, a simple apology can go a long way. Instead of over-apologizing, say something like, “*I apologize for using the wrong pronoun [or preferred name]. I did not mean to disrespect you.*” It can be tempting to overstate how badly you feel about making a mistake, but that

Box 1-6. Obtaining Patients’ Preferred Method of Address

Example:

Student: *“Good morning. I am Susannah Velasquez, a third-year clinical student. I am part of the clinical team taking care of you. I’m here to help make sure we’re meeting your needs. Are you Richard Clarkson?”*
Patient: *“Yes, that’s me.”*
Student: *“Thank you. How would you like me to address you?”*
Patient: *“You can call me Mr. Clarkson.” Or, “Richard is fine.”*

Box 1-7. Obtaining Patients’ Gender Pronouns

Example:

Student: *“Good morning. I am Susannah Velasquez, a third-year clinical student. I am part of the clinical team taking care of you and will assist them figure out how we can best help you. Are you Richard Clarkson?”*
Patient: *“Yes.”*
Student: *“How would you like me to address you?”*
Patient: *“You can call me Mr. Clarkson.” Or, “Richard is fine.”*
Student: *“It is a pleasure to meet you, Mr. Clarkson. Please feel free to call me Susie. May I ask you a few more background questions before we start?”*
Patient: *“Sure.”*
Student: *“In our effort to promote an inclusive and respectful environment, we like to use each other’s correct pronouns. The pronouns I prefer when others refer to me are ‘she’ and ‘her’. How about you? What pronouns do you prefer?”*
Patient: *“I use ‘he’ and ‘him,’ I guess.”*

Box 1-8. Steps in Stage 2: Gathering Information

Steps	Description
Initiate information gathering	After establishing rapport, ask the patient about their chief complaint or presenting problem(s), taking notes during the interview to ensure nothing is missed (Box 1-9).
Establish the agenda for the patient encounter[33]	Ask open-ended questions to encourage patients to discuss all of their concerns, not just clinical ones. You should identify all concerns and ask about missed ones to prioritize them.
Invite the patient's story[33]	Encourage patients to share their stories in their own words using an open-ended approach, actively listening without interrupting or injecting new information to prevent bias.
Gather information about the patient's perspective of illness	Explore the patient's perspective on their illness by using different types of questions to uncover their feelings, ideas, the effect on their function, and expectations (Box 1-10).
Identify and respond to the patient's emotional cues[34,35]	Check for emotional cues and feelings by asking about them, as visits tend to be longer when you miss emotional cues. See Box 1-11 for suggested techniques.
Gather information by exploring the biomedical perspective	The health history format is a structured framework for gathering and organizing patient information in written or verbal form. It focuses one's attention on the specific kinds of information clinicians need to obtain, facilitates clinical reasoning, and standardizes communication with other health care providers.
Gather important background information and context[36]	Learn about the patient's life circumstances, emotional health, perception of health care, health behaviors, and access to and utilization of health care to strengthen the therapeutic alliance and improve health outcomes.

might make the misgendered patient feel more awkward and inclined to comfort you, which is not appropriate.

Stage 2: Gathering Information

This stage has two functions: *gathering* and *providing information* (Box 1-8).[14] Clinicians gather information from patients regarding symptoms, experiences, and expectations to establish a diagnosis and treatment plan. Simultaneously, patients require information to comprehend their health issues, mitigate uncertainties, and support their coping mechanisms. This phase lays the groundwork for shared decision making later in the clinical encounter.

To explore the patient's perspective, use different types of questions. A mnemonic for the patient's perspective on the illness is *FIFE—Feelings, Ideas, effect on Function, and Expectations* (Box 1-12). The combination of concerns and expectations has been shown to have a major influence on the patient's decision to seek help from a clinician.

Box 1-9. A Note about Taking Notes

- Jot down or type short phrases, specific dates, or words; but do not let note-taking or the keyboard and computer screen distract you from the patient.
- Maintain good eye contact (Fig. 1-6). If the patient is talking about sensitive or disturbing material, put down your pen or move away from the keyboard.
- For patients who find note taking uncomfortable, explore their concerns and explain your need to make an accurate record.
- When using an electronic health record, face the patient directly as you elicit the patient's story, maintaining good eye contact and observing nonverbal behaviors; turn to the screen only after engaging the patient in the goals for the visit.
- Look up at the patient as often as possible, readjusting your screen and position if needed.[99]

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FIGURE 1-6. Maintain good eye contact.

Stage 3: Performing the Physical Examination

The physical examination also enhances your relationship with the patient. Physical findings denote the presence or absence of disease and an opportunity for you to learn more about your patient's outlook and condition. Since the physical examination almost always follows the history, it provides an avenue for the patient to talk about deeper fears or more serious issues. Maintain your patient's comfort throughout, avoid embarrassment, and demonstrate facility with the skills of physical examination to enhance the patient's satisfaction with the clinical encounter.[37]

Box 1-10. Clues to the Patient's Perspective on Illness

- Direct statement(s) by the patient of explanations, emotions, expectations, and effects of the illness
- Expression of feelings about the illness without naming the illness
- Attempts to explain or understand symptoms
- Speech clues (e.g., repetition, prolonged reflective pauses)
- Sharing a personal story
- Behavioral clues indicative of unidentified concerns, dissatisfaction, or unmet needs such as reluctance to accept recommendations, seeking a second opinion, or early return appointment

Source: Lang F, Floyd MR, Beine KL. Clues to patients' explanations and concerns about their illnesses. A call for active listening. *Arch Fam Med*. 2000;9(3):222–227.

Box 1-11. Responding to Emotional Cues Using NURSE Statements[100,101]

Learn to respond attentively to emotional cues using techniques like reflection, feedback, and "continuers" that convey support. A mnemonic for responding to emotional cues is NURSE:

Name: *"That sounds like a scary experience"*
Understand or legitimize: *"It's understandable that you feel that way"*
Respect: *"You've done better than most people would with this"*
Support: *"I will continue to work with you on this"*
Explore: *"How else were you feeling about it?"*

Source: Communication: what do patients want and need? *J Oncol Pract*. 2008;4(5):249–253; Pollak KI, Arnold RM, Jeffreys AS, et al. Oncologist communication about emotion during visits with patients with advanced cancer. *J Clin Oncol*. 2007;25(36):5748–5752.

Stage 4: Explaining and Planning

This stage includes the elaboration of the patient's chief concerns from the disease and illness perspectives. Your goal is to assess and respond to the patient's needs for information. To achieve a shared understanding, make it easy for the patient to understand and remember your explanations and encourage mutual discussion rather than one-way communication. This will allow your patients to understand shared clinical decision making, determine how much they want to be involved, and hopefully increase their commitment to the plans made.

Box 1-12. Exploring the Patient's Perspective (F-I-F-E)[3,6]

- The patient's **F**eelings, including fears or concerns, about the problem
- The patient's **I**deas about the nature and the cause of the problem
- The effect of the problem on the patient's life and **F**unction
- The patient's **E**xpectations of the disease, of the clinician, or of health care, often based on prior personal or family experiences

Source: Fortin AH VI, Dwamena FC, Frankel RM, Smith RC. *Smith's Patient-Centered Interviewing: An Evidence-Based Method*. 3rd ed. McGraw-Hill Medical; 2012; Mauksch L, Farber S, Greer HT. Design, dissemination, and evaluation of an advanced communication elective at seven U.S. medical schools. *Acad Med*. 2013;88(6):843–851.

Provide Useful Information and Verify Patient Understanding.[38–40] Studies show that patients forget up to 80% of the clinical information provided during office visits, with nearly half of the information retained being incorrect. To verify the patient's understanding of the plan of care, the *"teach-back" technique* can be used, in which the patient is asked to explain the plan of care in their own words. The *"show-me" method* can also be used to confirm that patients can follow specific instructions (Box 1-13).

Negotiate the Plan of Action through Shared Decision Making.[41,42] Interactive history taking creates a shared understanding of the patient's issues, serving as a basis for further evaluation and treatment planning. *Shared decision making* involves a three-step process of introducing choices, exploring patient preferences, and moving to a decision while checking for readiness and offering additional time if needed. This approach promotes optimal therapy, treatment adherence, and patient satisfaction. It may be necessary to explain recommendations multiple times to ensure the patient understands and agrees with the proposed plan.

Stage 5: Closing the Encounter

Ending the interview or visit can be challenging since patients often have numerous questions and feel engaged if the clinician has done their job well. Inform the patient of the approaching end to allow for any final questions, but avoid bringing up a new topic during the last few minutes, unless it concerns a life-threatening issue. Instead, assure the patient of your interest and arrange to address the issue at a future time. Reaffirming your commitment to the patient's health shows involvement and esteem. Summarizing the mutual plans developed with the patient before leaving the room and asking if they have any questions about what was discussed is helpful.

Self-reflection or mindfulness is crucial in developing clinical empathy. *Mindfulness* involves being purposefully and nonjudgmentally attentive to your own experience, thoughts, and feelings.[43] Given patients' diverse backgrounds, being consistently respectful and open to individual differences is an ongoing challenge in clinical care. Since clinicians bring their values, assumptions, and biases to every encounter, looking inward is necessary to understand how our expectations and reactions impact our behavior and communication. Self-reflection is a continuous part of professional development in clinical work that brings personal awareness to patient care and is one of the most rewarding aspects of it.[44,45]

Box 1-13. Teach-Back Method

- **Plan your approach.** Think about how you will ask your patient to teach back the information. An example would be: *"We covered a lot today and I want to make sure that I explained things clearly. So, let's review what we discussed. Can you please describe the three things you agreed to do to help you control your diabetes?"*
- **"Chunk and Check."** Don't wait until the end of the visit to initiate teach-back. Chunk out information into small segments and have your patient teach it back. Repeat several times during a visit.
- **Clarify and check again.** If teach-back uncovers a misunderstanding, explain things again using a different approach. Ask patients to teach-back again until they are able to correctly describe the information in their own words. If they parrot your words back to you, they may not have understood.
- **Start slowly and use consistently.** At first, you may want to try teach-back with the last patient of the day. Once you are comfortable with the technique, use teach-back with everyone, every time!
- **Practice.** It will take a little time, but once it is part of your routine, teach-back can be done without awkwardness and does not lengthen a visit.
- **Use the *show-me* method.** When prescribing new medicines or changing a dose, research shows that even when patients correctly say when and how much medicine they will take, many will make mistakes when asked to demonstrate the dose.
- **Use handouts along with teach-back.** Write down key information to help patients remember instructions at home. Point out important information by reviewing written materials to reinforce your patients' understanding. You can allow patients to refer to handouts when using teach-back, but make sure they use their own words and are not reading the material back verbatim.

Source: Use the Teach-Back Method: Tool #5. Content last reviewed September 2020. Agency for Healthcare Research and Quality. Accessed June 16, 2023. https://www.ahrq.gov/health-literacy/improve/precautions/tool5.html

DISPARITIES IN HEALTH CARE

Disparities in risks of disease, morbidity, and mortality are marked and broadly documented across different population groups, reflecting inequities in health care access, income level, type of insurance, educational level,

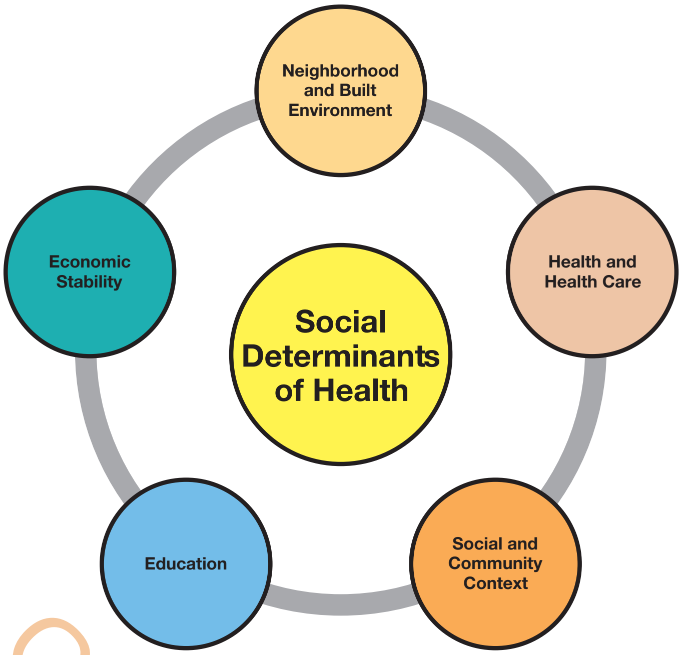
Neighborhood and Built Environment
Economic Stability
Social Determinants of Health
Health and Health Care
Education
Social and Community Context

FIGURE 1-7. Social determinants of health. (Adapted from HealthyPeople2030 at https://www.healthypeople.gov.)

language proficiency, and provider decision making.[45,46] This section focuses on important factors that potentiate unequal treatment in the clinical encounter and approaches to help mitigate them.

Social Determinants of Health

Health is significantly affected by the social environment, also known as the *social determinants of health (SDOH)*. The World Health Organization (WHO) defines SDOH as "the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life" (Fig. 1-7). This includes economic policies and systems, development agendas, social norms, social policies, and political systems.[48] In short, these are the social, economic, and political factors that impact the health of individuals and populations (Box 1-14).[47] More than their genetic susceptibilities, patients' health is often influenced by SDOH such as stress, early life, social exclusion, working conditions, unemployment, social support, addiction, healthy food, and transportation policies. Evidence supports addressing social determinants of health to improve patient health and reduce inequities (Box 1-15).[49]

Racism and Bias

Research indicates that implicit clinician biases can negatively impact patient encounters and contribute to health care disparities among different demographic groups.[51]

Box 1-14. Key Social Health Determinant Domains

- **Economic stability** (employment, food insecurity, housing instability, poverty)
- **Education access and quality** (early childhood education and development, enrollment in higher education, high school graduation, language, and literacy)
- **Social and community context** (civic participation, discrimination, incarceration, social cohesion)
- **Health care access and quality** (access to health care, access to primary care, health literacy)
- **Neighborhood and built environment** (access to foods that support healthy eating patterns, crime and violence, environmental conditions, quality of housing)

Source: Healthy People 2030, U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. Accessed June 16, 2023. https://health.gov/healthypeople/objectives-and-data/social-determinants-health

Unconscious mental processes help sort and organize patterns to improve cognitive efficiency, leading to implicit biases formed by society's exposure to imagery, values, media, and emotions depicting stereotypes associated with different demographic groups. Addressing implicit bias in clinical encounters requires understanding its cognitive origins and acknowledging its relation to explicit bias (Box 1-16).[53]

Several skills are available that clinicians can use to mitigate the impact of bias in their clinical encounters (Box 1-17).

Box 1-15. Addressing Social Determinants of Health

Level of Interventions	Sample Actions
Patient level	Identify social challenges Offer culturally safe services Help patients access benefits and support services
Practice level	Use patient navigators to ensure care is accessible to those most in need
Community level	Partner with local organizations Engage in health planning Improve environments for health

Box 1-16. Types of Bias

Type of Bias	Description	Example Scenarios
Implicit Bias	Unconscious evaluation of a person based on perceived group identity, leading to negative associations[50] Can negatively impact patient encounters and contribute to health care disparities among different demographic groups Can manifest in nonverbal behaviors and contribute to institutional bias	Assuming a female doctor holds a different role, such as a nurse Audibly sighing in frustration about a patient's substance use disorder Poor eye contact and speech errors that may unintentionally convey distrust or discomfort
Explicit Bias	Conscious decision based on beliefs or associations regarding group identity Patient characteristics such as race, gender, sexual orientation, and age can influence communication, diagnostic decision making, treatment recommendations, and nonverbal behaviors	Assuming a particular health condition is more likely to affect patients based on their race. Offering different treatment options based on gender Making negative comments about a patient's age or sexual orientation
Institutional Bias	Refers to the aggregation of implicit biases that lead to a structural system of privilege[52–56] Misallocates care for marginalized groups	Limiting access to care for certain demographic groups Offering unequal treatment options based on social identities Disregarding patient symptoms or concerns based on assumptions linked to identity

Box 1-17. Skills and Practices to Mitigate Bias in Your Clinical Encounters[55,56,102]

Reflect on patterns of emotion and behavior.	Pay attention to how you feel and how you behave around patients of different identities. The patterns you recognize may reflect biases that impact your interactions with patients as well as your clinical reasoning. Being aware of these biases is the first step in reducing their impact on patient care.
Pause before starting an encounter and prepare for potential triggers of bias	Once you are aware of your potential biases, pay attention to situations that may trigger them. Simply being aware of a bias can help minimize its effect. You may take deliberate actions to reduce the impact of your biases.
Generate alternative hypotheses for biases anchored in behavior	Many biases are anchored in clinician assumptions about observed patient behavior (nonadherence, substance use, etc.). Make it a habit to consider what structural forces (socioeconomic status, race/racism, homophobia, etc.) impact patient behaviors, and how they can challenge assumptions you make about patients.
Practice universal communication and interpersonal skills	Often, clinicians will not recognize when a bias is at play in a clinical encounter. The foundational communication and interpersonal skills described in this book (see Chapter 2, Interviewing, Communication, and Interpersonal Skills, p. 21) can reduce the impact of such truly unconscious biases on the way you interact with patients.
Explore your patients' identities	Many biases are anchored in clinician assumptions about patient identities. By simply asking patients to clarify what their identities mean to them, clinicians can dismantle their assumptions and better understand their patients. Many approaches to exploring patient identities are presented in this book (see pp. 52–53).

Explore your patients' experiences of bias	Clinical encounters are influenced by patients' prior experiences of implicit and explicit bias in their health care. Exploring and understanding these experiences can help you be a better partner with your patients. "Unfortunately, many of my patients have had negative experiences with health care. What have been your experiences with health care?"

Source: Burgess DJ, Fu SS, van Ryn M. Why do providers contribute to disparities and what can be done about it? *J Gen Intern Med*. 2004;19(11):1154–1159; Stone J, Moskowitz GB. Non-conscious bias in medical decision making: what can be done to reduce it? *Med Educ*. 2011;45(8):768–776; van Ryn M, Burgess DJ, Dovidio JF, et al. The impact of racism on clinician cognition, behavior, and clinical decision making. *Du Bois Rev*. 2011;8(1):199–218.

Cultural Humility

Cultural humility helps clinicians acknowledge and respect patients' individuality, mitigate implicit bias, and promote empathy. It involves self-reflection and critique as lifelong learners, examining cultural beliefs and systems to locate points of dissonance or synergy that contribute to patients' health outcomes.[57,58] To moderate disparities in health care, clinicians should engage in self-reflection, critical thinking, and cultural humility as they experience diversity in their clinical practices.[59–61] This process calls for clinicians to address power imbalances in communication with patients and maintain mutually respectful partnerships with patients and communities (Box 1-18).[62–66]

Box 1-18. Three Dimensions of Cultural Humility

Self-Awareness

Cultural humility begins with examining our own cultural identity, values, and biases. Overcoming biases, which are natural, but can influence our perceptions of others, is crucial.

For example, a clinician who grew up in a culture that stigmatizes mental health issues may need to challenge their own biases when working with a patient who is seeking treatment for depression. The clinician should recognize their own biases and strive to understand and respect the patient's cultural beliefs and values around mental health.

Respectful Communication

To provide culturally sensitive care, you should let patients lead the conversation about their unique cultural perspectives. Specific questions and an open, respectful attitude can elicit important information. You should be mindful of assumptions and acknowledge your own biases. Learning about a patient's culture can broaden understanding of their needs, but you should avoid stereotyping and research the life experiences of individuals in ethnic or racial groups in their area. Talking to different healers can also expand your knowledge.

For example, a clinician treating a patient from a culture that values natural remedies may need to ask specific questions about the remedies the patient is using and how they fit into the patient's overall treatment plan. The clinician should avoid making assumptions about the effectiveness or safety of these remedies and instead seek to understand the patient's cultural beliefs and values regarding health care.

Collaborative Partnerships

You can promote better health outcomes by cultivating self-awareness and empathy, building collaborative relationships with patients through respectful communication and openness to diverse perspectives. You should validate patients' emotions, remain flexible in treatment planning, and re-examine your own assumptions about clinical care. Success of care is determined by the patient's engagement and investment in your treatment plan.

For example, a clinician may need to collaborate with a patient from a culture that values community involvement in health care decisions. The clinician should be willing to engage with the patient's community and involve them in the patient's treatment plan. The clinician should also be willing to re-examine their own assumptions about what constitutes effective health care and work with the patient to develop a plan that reflects the patient's beliefs and values. The success of the plan will depend on whether the patient feels engaged and invested in the treatment.

Box 1-19. 5Rs of Cultural Humility

	Aim	Ask
Reflection	Clinicians will approach every encounter with humility and understanding that there is always something to learn from everyone.	What did I learn from each person in that encounter?
Respect	Clinicians will treat every person with the utmost respect and strive to preserve dignity at all times.	Did I treat everyone involved in that encounter respectfully?
Regard	Clinicians will hold every person in their highest regard, be aware of, and not allow unconscious biases to interfere in any interactions.	Did unconscious biases drive this interaction?
Relevance	Clinicians will expect cultural humility to be relevant and apply this practice to every encounter.	How was cultural humility relevant in this encounter?
Resiliency	Clinicians will embody the practice of cultural humility to enhance personal resiliency and global compassion.	How was my personal resiliency affected by this interaction?

Source: The 5Rs of Cultural Humility. Reprinted with permission from Society of Hospital Medicine. Accessed June 16, 2023. https://www.hospitalmedicine.org/practice-management/the-5-rs-of-cultural-humility/

The 5Rs of Cultural Humility *(reflection, respect, regard, relevance, and resiliency)* is a coaching tool (Box 1-19) that provides clinicians with a concise framework with specific aims and asks to incorporate skills identified at reducing implicit biases in health care.[67]

OTHER MAJOR CONSIDERATIONS

Other Major Considerations

- Spirituality
- Medical Ethics
- Decisional Capacity
- Approach to a Clinical Ethical Dilemma

Spirituality

Spirituality and religion are sometimes used interchangeably, but it is important to differentiate the two. *Spirituality* is a broader concept that encompasses religion, focusing on universal themes such as meaning, purpose, transcendence, and connection with others. It refers to the way individuals seek and express meaning and purpose and experience their connectedness to the moment, self, others, nature, and the significant and sacred.[68] *Religion*, on the other hand, involves specific beliefs, practices, texts, and rituals common to a community in relation to something larger than themselves, such as God, the holy, the transcendent, or a higher power.

Respecting patients' religious and spiritual beliefs is essential in culturally competent care. Box 1-20 provides questions to assess spirituality's role in health decisions and coping, while Box 1-21 outlines respectful practices for discussing beliefs in clinical settings.

Medical Ethics

While many clinicians have a general sense of right and wrong, the complexity and uncertainty of clinical situations require a more comprehensive set of ethical principles to guide decision making (Box 1-22).

Medical ethics is a subdiscipline of applied ethics, which itself is a subdiscipline of philosophy. It has an ancient heritage, typically traced back to the Hippocratic Oath, which includes principles such as beneficence, confidentiality, and nonmaleficence. However, this oath also reflected a paternalistic approach to medicine, which remained dominant as the profession became more formalized in the 18th century.[76,77]

In the 20th century, there were several events that challenged this dominant ethic of paternalism. Court decisions such as Schloendorff versus Society of New York Hospital established the need for clinicians to obtain informed consent from patients before treatment.[78] Additionally, revelations of physician misconduct, such as the Nazi doctors and the U.S. Tuskegee Syphilis study, led to a further reassessment of medical ethics.[79,80]

Box 1-20. Guiding Questions in Assessing the Role of Spirituality in Your Patient

- What values guide your patient's health care decisions?
  - Does your patient consult a religious/spiritual leader before making important health care decisions?
  - Does your patient have particular religious/spiritual concerns about blood products or porcine implants?
- How do patient spiritual beliefs and practices influence how they cope with their illness and care for themselves?[103]
  - Is there a significant community involved who may aid them while they are sick?
  - Is there a spiritual practice such as yoga or meditation that may aid them in their healing?
- Does your patient have spiritual struggle or distress and need a referral to a chaplain?
  - *Spiritual struggle* is defined as "...tensions, conflicts, and questions over sacred matters within oneself, with others, and with God."[104] Examples include feeling abandoned by God or one's religious community, a belief that the universe is out to get you, or doubts about one's fundamental beliefs and values.
  - Spiritual struggle has been shown to increase depressive symptoms, emotional distress, and risk of mortality while decreasing physical health, quality of life, and recovery of independence in daily activities.[105]

Box 1-21. Do's and Don'ts for Religious and Spiritual Beliefs in Clinical Encounters

Don't assume that patients are religious.	In the United States, 27% of adults identify as "spiritual, but not religious."[70,71]
Don't assume that patients are not religious.	Nearly 75% of U.S. adults identify as religious.[72]
Don't assume that you know what religion or spirituality means to the patient.	Patients often customize their beliefs and practices, so taking a spiritual history is important.
Don't assume that religion or spirituality has no effect on health.	Religion and spirituality can be social determinants of health and impact health outcomes positively or negatively. For example, Seventh-Day Adventists who follow a vegetarian diet for religious reasons live an average of 10 years longer than most Americans. On the other hand, medically ill older adult patients who feel that God has abandoned them have an increased risk of death.[73–75]
Do take a spiritual history.	Ask patients about their spiritual or religious beliefs, practices, and community involvement to understand how they may affect their health and health care decisions.
Do use nonjudgmental language.	Avoid imposing your beliefs on the patient or making assumptions. Use open-ended questions to encourage patients to share their beliefs and experiences.
Do be respectful of the patient's beliefs.	Show empathy and understanding toward their religious or spiritual practices and support their autonomy in making health care decisions that align with their beliefs.
Do be aware of resources available.	Accessing resources like chaplains or spiritual advisors can help provide additional support to patients.

Box 1-22. Core Values of Medical Ethics

- ***Nonmaleficence*** *("first, do no harm")* directive that health care professionals should avoid causing harm to patients and minimize the negative effects of treatments.
- ***Beneficence*** dictum that clinicians are to act for the patients' good by preventing or treating disease.
- ***Respect for autonomy*** commitment to accept the choices patients with decisional capacity make about which treatments to undergo, including to reject treatment. The addition of this value to medical ethics changed the clinician–patient relationship from a paternalistic one to a more collaborative one.
- ***Decisional capacity*** ability to make an autonomous choice that clinicians should respect.[83]
- ***Confidentiality*** duty to prevent the disclosure of patients' personal information to parties who are not authorized to learn that information.
- ***Informed consent*** principle that clinicians must elicit patients' voluntary and informed authorization to test or treat them for illness or injury. Because patients cannot consent to treatment without knowing what they are being treated for, this principle also encompasses the responsibility to inform patients of diagnoses, prognoses, and treatment alternatives.
- ***Truth telling*** value that clinicians should disclose information beyond that required by informed consent that may be relevant to patients (e.g., the number of similar procedures a physician has performed).
- ***Justice*** value that all patients with similar medical needs should receive similar medical treatment and should be treated fairly by clinicians.

As a response, there was a "bioethics revolution" in the mid-20th century, led by philosophers and theologians, which retained the older principles of Hippocratic and professional values, while also establishing respect for patient autonomy as a core value of medicine. This respect for autonomy empowered patients to make health choices that reflect their own views of what is good for them. Respect for autonomy, along with beneficence, nonmaleficence, and justice, became established as the common core of health care ethics and are now incorporated into most professional codes for health care providers.[81,82]

Decisional Capacity

Capacity and competence are two distinct concepts in health care. *Capacity* is a clinical designation that clinicians can assess, while *competence* is a judicial determination that only a court can make. Determining a patient's capacity to make informed health care decisions is important, and it involves assessing their ability to communicate a choice, understand relevant information, appreciate the situation and its consequences, and reason about treatment options (Box 1-23).[83]

Box 1-23. Elements of Decisional Capacity

Patients must have the ability to:

- Understand the relevant information about proposed diagnostic tests or treatment
- Appreciate their situation (including their underlying values and current clinical situation)
- Use reason to make a decision
- Communicate their choice

Source: Sessums LL, Zembrzuska H, Jackson JL. Does this patient have medical decision-making capacity? *JAMA*. 2011;306(4):420–427.

If a patient lacks capacity, identifying a health care proxy or surrogate decision maker is necessary, and this role may be assumed by a spouse or family member if the patient has not designated one. Importantly, decisional capacity is both temporal and situational and can fluctuate depending on the patient's condition and the complexity of the decision at hand.[84,85]

Approach to a Clinical Ethical Dilemma

Medical ethics is a crucial aspect of every clinical encounter with patients, even though it may not always be explicitly considered. As students, you will be exposed to ethical challenges that you may encounter in your future practice as clinicians. While adhering to ethical values becomes a natural part of clinical practice through training, some complex cases may require explicit and critical reflection to determine the ethical course of action. In such situations, heuristics can provide guidance on how to approach ethical dilemmas (Box 1-24).[86–88] While these practical methods may not guarantee an optimal or perfect solution, they can help achieve an immediate goal and lead to a satisfactory solution in situations where finding an optimal one is impossible or impractical.

Box 1-24. How to Resolve a Clinical Ethical Dilemma

Step	Description
1	Formulate an ethics question that summarizes the challenge they face in an ethically complex clinical situation.
2	Collect all of the information that clinicians believe is relevant to the case, including clinical information, patient's goals, preferences, cultural or religious commitments, financial resources, and interests and concerns of other stakeholders.
3	Identify the ethical principles and guidelines, including laws, institutional policies, and ethics concepts, that would guide the clinician's conduct in the case.
4	Reflect on how the relevant principles identified in the prior step would guide their conduct in the case and clarify the ethical dilemma if there is any.
5	Evaluate the different options and decide which ethical concept is the most important in the case and follow its guidance.
6	Make an action plan on how to communicate the decision and plan how to implement the ethical course of action. Enlist institutional support from an ethics consultant or committee and other services, such as social work services, if necessary.

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CHAPTER

2

Interviewing, Communication, and Interpersonal Skills

Choosing to enter the health care professions is a significant decision, often driven by the desire to foster effective, healing relationships—a cornerstone of patient care.[1] This chapter delves into the essential techniques of therapeutic interviewing, skills that require continual refinement throughout your career. Such skills are not innate; they necessitate diligent practice and constructive feedback from mentors to enhance your proficiency. As you gain experience, you will become adept at selecting the most appropriate techniques to navigate the complex dynamics of human behavior within patient relationships.

Chapter 1 introduced the concept that clinical interviewing transcends a mere exchange of questions and answers. It demands a nuanced sensitivity to patients' emotional and behavioral signals (Fig. 2-1). This approach allows you to weave together a patient's narrative in a way that is both dynamic and responsive to their cues, emotions, and concerns.[2]

FIGURE 2-1. The interviewing process using effective communication skills.

Chapter 1 also highlighted that the competencies required for effective interviewing diverge significantly from those used in compiling a health history. While the health history format is crucial for categorizing a patient's medical story into relevant sections (present, past, and family health), it serves a different purpose from the interview process. The interview is about building a connection and understanding, whereas the health history provides a structured overview of the patient's medical background. As you explore the art of skilled interviewing in this chapter, appreciate the distinct yet complementary roles of these two aspects.

See Chapter 3, Health History, for the format of the health history, pp. 47–61.

Chapter Content Guide

- Organizing Patient–Clinician Communication Strategies
- Establishing the Foundation of Communication
- Building the Interaction
- Strengthening the Relationship
- Addressing Sensitive Topics
- Practicing Legal and Ethical Communication
- Using Advanced Communication Strategies
- Navigating Complex Discussions
- Encouraging Patient Self-Efficacy
- Enhancing Interprofessional Communication
- Managing Challenging Patient Situations and Behaviors
- Being Patient-Centered in Computerized Clinical Settings
- Learning Communication Skills from Standardized Patients